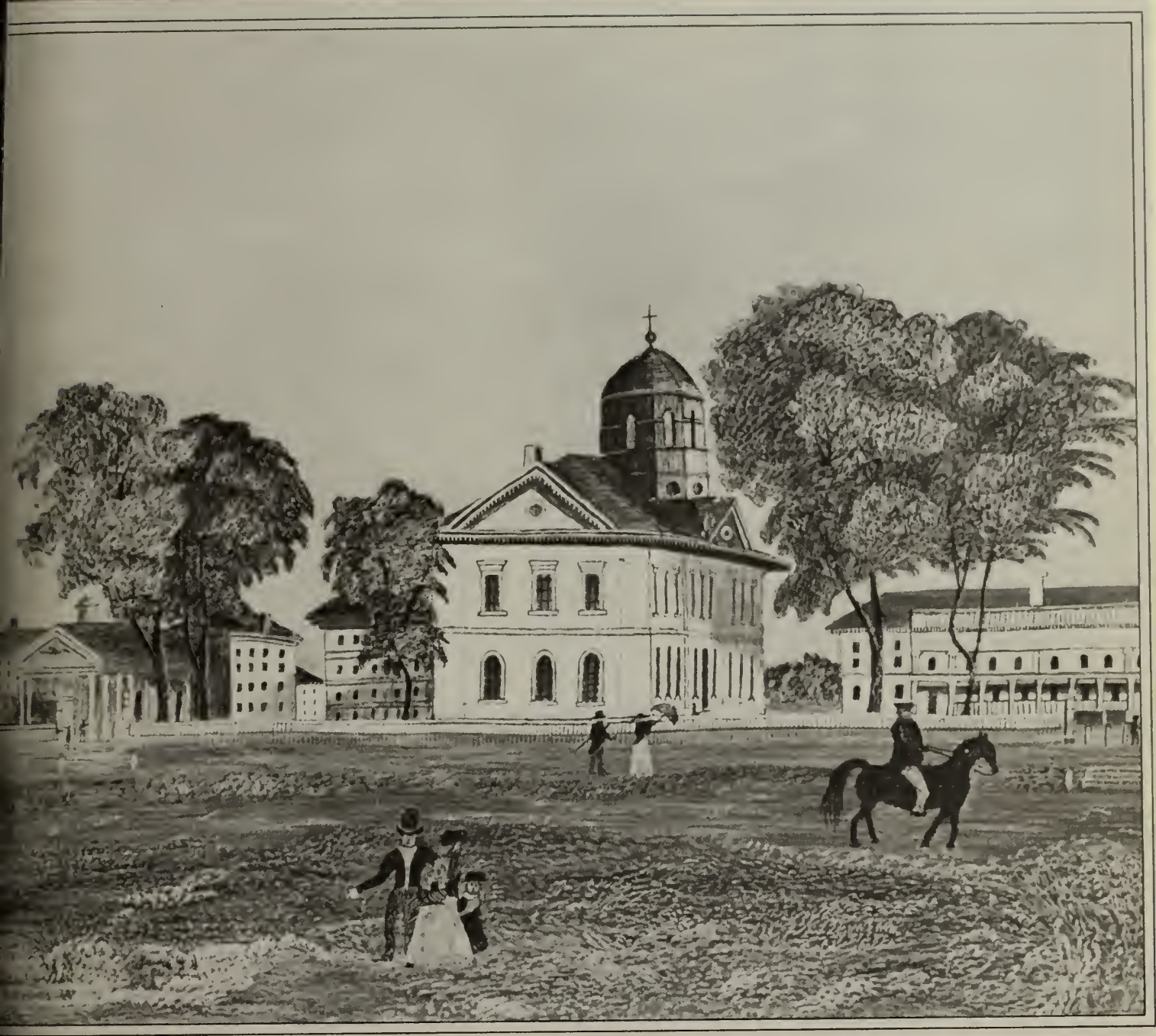


Harvard Medical Alumni Bulletin

November/December 1977

If you're going to locat relocate, expand, we can handle *everything.*

The Healthco Physicians' Office Design & Equipment Center is unique in its ability to provide a fu range of problem-oriented services that the indivi ual physician or group practice require. Our areas of concentration:

- Evaluation of your present or prospective location.
- Design of the office or professional building . . . and management of construction.
- Selection of equipment for any practice . . . solo, group, clinic, industrial; and any specialty.
- Financing construction and/or equipment.
- Leasing equipment.
- Consultation on financial and other aspects c all capital investments related to medical practice.
- Practice management matters . . . patient flo paper flow, forms, and the myriad details tha can make the difference between a well-managed practice and one that just "happens

These services are performed by a staff of skilled designers and equipment specialists, working in modern display rooms showing the latest equipment. Our staff and the outside consultants with whom they frequently collaborate, are careful to work within your budget.

Our Center is an arm of Healthco's full-service medical supply network, and we are happy to provide our customers with this complete service. If you would like to see examples of our work, or hav our help in any of the areas outlined, drop in or phone collect.

Healthco

Physicians' Office Design & Equipment Center
25 Stuart Street, Boston, Mass. 02116
(617) 542-1163; 423-6045

Harvard Medical Alumni Bulletin

november/december 1977 vol. 52 no. 2

The *Harvard Medical Alumni Bulletin* is published bi-monthly at 25 Shattuck St., Boston, Mass. 02115. Third class postage paid at Burlington, Vermont.

Credits: p. 2, Diane Andronica; pp. 2, 3, 47, Rick Stafford; pp. 9, 12, Rare Book Room of the Countway Library; pp. 13, 17-18, 22, 25-26, Bradford F. Herzog; p. 13, top right, courtesy of Doris Appel; pp. 14, 19, Dan Bernstein; pp. 15-16, Fredrik D. Bodin; pp. 20, 23, top right, 26, The Aluminium Association; p. 21, John Sharratt Associates, Inc.; pp. 23-24, courtesy of Roxbury Tenants of Harvard; pp. 27-29, courtesy of Mrs. Mary Howe Fulton; pp. 30-33, courtesy of Steve Gottlieb '78, who participated in the Rincón, Puerto Rico program in July and August 1977. We would also like to thank Ms. Janet Blowney and Ms. Joanne O'Brien, of the Affiliated Hospitals Center's public relations office, who helped us gather the photographs by Messieurs Bernstein and Herzog.

Cover: an original drawing, whose artist is unknown, shows Harvard Yard — a familiar scene of engravings of the early eighteenth through the late nineteenth centuries. Holden Chapel, which housed the Medical School from 1782 until 1810 is the low building at the far left. The actual date of the drawing is not certain, but it was probably done in the mid-nineteenth century, inspired by an earlier print. We thank its owner, Dr. Mark A. Altschule, for allowing us to borrow what he calls "A muddy day in Harvard Square" for our cover.

Overview

Mudd laboratories open for research

"A place for that creative dreaming we call scientific research" was how Dean Daniel C. Tosteson characterized the new Seeley G. Mudd Building at its dedication on October 18. Expanded biochemical research programs and a new department of pharmacology will reside in the new quarters, along with research activities of clinical staff members from the Boston Hospital for Women and the Robert Breck Brigham Hospital.

Dr. Carl M. Franklin, vice-chairman of the Seeley G. Mudd Fund, presented the building to Harvard on behalf of the fund's trustees. Dr. Mudd, a member of the Class of 1924, and a scientist, engineer, financier and philanthropist, bequeathed the principal and interest of his estate for the construction of teaching and research facilities at leading colleges and universities; more than $44 million will be given to thirty-four institutions around the country. The Mudd Fund's contribution to Harvard was supplemented by funds from the Monsanto Corporation, the Boston Hospital for Women, the Robert Breck Brigham Hospital, and the University itself to equal the $9 million needed to make the Seeley G. Mudd Building a reality.

Keynote speaker at the dedication was Dr. Donald Kennedy, commissioner of the Food and Drug Administration, who framed a challenge for institutions and individuals conducting biomedical research in the years to come, "to lift their sights and to focus them more on actual benefits to population health than on the immediate work product of their own laboratories. However painful this may be, I think it is an appropriate challenge. In particular, we should be asking whether the research and education we do are adequately directed at important questions instead of merely answerable ones." He stressed the obligation "to apply the fruits of knowledge with wisdom and caution. Often that requires knowledge of a different sort, and I hope that great institutions can find a way to do both."

Getting at the roots of mental illness

"One of the things I would like to get across to the public is the crucial nature of basic research into the causes of mental illness." Mrs. Rosalyn Carter was speaking at the October 3 dedication of the Mailman Research Center at McLean Hospital in Belmont, Massachusetts — a place to be devoted to just this sort of study. "The concept of this center — which is to provide services to patients as well as to conduct basic research and train young professionals — is the hallmark of institutions of excellence," said Mrs. Carter.

The Mailman Center is designed as an environment in which basic scientists can collaborate with psychiatrists in conducting clinical studies of the mentally ill. Completed at a cost of $3.28 million, it houses two major research units: the Laboratories for Psychiatric Research, directed by Seymour S. Kety, M.D., professor of psychiatry at

Mrs. Rosalynn Carter

The Mailman Research Center at McLean Hospital, created by an addition of two floors to the existing research building.

HMS; and the Ralph Lowell Laboratories, under Alfred Pope '41, professor of neuropathology. McLean Hospital itself is a division of the Massachusetts General Hospital and a Harvard teaching hospital, with 324 beds. When it opened in 1818, it was the first psychiatric hospital in New England, and the third in the nation.

Francis deMarneffe, M.D., director of McLean and lecturer on psychiatry at Harvard, also offered some remarks at the dedication. He spoke of the need to make a clear distinction between social ills requiring political public health solutions, and mental illness needing medical and psychiatric approaches; and cautioned against what he perceived as increasing nonprofessionalism in the mental health field.

The principal lines of research to be pursued at the Mailman Center and their section chiefs are as follows:

Genetics, Seymour S. Kety, M.D.: studies aimed at differentiating genetic and environmental factors in mental illness.

Neuroanatomy, Dr. Walle Nauta, Institute Professor, MIT: investigating the structure and anatomical relationships of certain brain systems thought to be related to emotions, and to the responses of psychotic patients to medication.

Neuropharmacology, Ross Baldessarini, M.D., associate professor of psychiatry, HMS: laboratory and clinical studies of the chemistry and actions of drugs used to treat major psychiatric disorders.

Neurochemistry, Jeffrey Gilbert, M.D., assistant professor of psychiatry, HMS: basic research to clarify biochemical-metabolic processes that are essential to the structure and function of brain nerve cells.

Psychology: studying attention abnormalities of schizophrenic patients, such as abnormal eye-tracking, responses to sound, and reaction times, to discover whether they are unique to schizophrenics, and how they respond to treatment.

Neuropathology, Alfred Pope, M.D.: analyzing the cellular components of human postmortem brain tissue, with the use of contemporary technologies.

Clinical research facility, Joseph Lipinski, M.D., assistant professor of psychiatry, HMS: an inpatient treatment unit at McLean has been established as the clinical research facility of the Mailman Center.

After the dedication ceremonies, Mrs. Carter, who has become an advocate of increasing federal attention to the needs of the mentally ill, spoke to the press about her work as honorary chairperson of the President's Commission on Mental Health. She enumerated some of the recommendations contained in the Commission's recent interim report:

1) Establish better coordination among the eleven federal agencies and more than one hundred mental health programs;

2) Encourage HUD to fund group homes;

3) Continue funds for community mental health centers at their present level, until new legislation can be drawn up expanding support. Less than half of the legislation's projected 1,500 community mental health centers have been set up so far;

4) Increase funding for research by twenty per cent for the National Institute of Mental Health, thirty per cent for the National Institute of Alcohol Abuse and Alcoholism, and thirty-five per cent for the National Institute of Drug Abuse;

5) Gather data on costs of insurance coverage for mental illness, as a necessary step in planning for national health insurance;

6) Define the scope of mental illness, and distinguish its biological, psychological, and social components, preliminary to the drafting of a national health insurance.

New deans divide their responsibilities

Over the past several months, in addressing the faculty, students and other groups, Dean Daniel C. Tosteson has begun to outline some of "my ideas about the Harvard Medical School, and the processes through which I hope to express these ideas." The administrative group of which Dr. Tosteson spoke at Alumni Day will consist of four senior deans:

The Dean for Academic Programs will be concerned with the educational programs leading to the M.D. and Ph.D. degrees, and with the organization of the faculty, the procedures for faculty appointments and promotions, and the coordination of research activities.

The Dean for Medical Services will be concerned with the interaction of the Medical School with the hospitals and other providers of health care affiliated with the School, and will be executive vice-president of the Harvard Medical Center. This will entail some involvement with graduate medical education and with the relationship between the Medical School and the government as well. Dr. Mitchell Spellman of Los Angeles, who for the past eight years has been dean of the Charles R. Drew Postgraduate Medical School, assumes his deanship at HMS January 1. He will also act as the faculty's representative in deliberations about health delivery policy with the university's affiliated institutions.

The Dean of Students and Alumni/ae is to be responsible for the areas of admissions, student records, student advising, and interactions with the Alumni Association. Daniel Federman '53 assumed this post on November 1, after serving as chairman of the department of medicine at Stanford University Medical Center for the past four years.

The Dean for Business and Finance will be Henry Meadow, who has filled this post, under a variety of similar titles, since 1951.

The School's financial base, Dr. Tosteson feels, is in need of bolstering: "The Harvard Medical School is relatively well endowed compared to most private medical schools. However, this should not obscure the fact that HMS is, in my view, seriously undercapitalized. Only about fourteen per cent of the total direct expenditures of the School is offset by income from endowment. If one takes into account expenditures for School programs by the affiliated hospitals, this figure drops to about five per cent. Equally alarming is the fact that annual contributions for capital amount to only about two per cent of the total value of the endowment, at a time when the annual rate of inflation is five per cent or more. Clearly, energetic efforts are necessary to increase the size of our stable financial base if the Harvard Medical School is to remain a strong and independent private institution, and to launch the new ventures which will lead medicine through the 1980s and beyond."

Uncle Sam beckons to two HMS faculty members

The Medical School faculty has lost two more men to one of its fiercest competitors — the federal government. Julius B. Richmond, M.D., former chairman of the department of preventive and social medicine and professor of child psychiatry and human development, was sworn in as Assistant Secretary for Health and Surgeon General at HEW on July 13; while Gerald Klerman, M.D., professor of psychiatry and director of the Stanley Cobb Laboratories for Psychiatric Research at the MGH, has recently assumed his responsibilities as director of the Alcohol, Drug Abuse and Mental Health Administration.

Greater attention to children's health programs is given high priority by Dr. Richmond, who was psychiatrist in chief at Children's Hospital Medical Center and director of the Judge Baker Guidance Center, a mental health facility for children and their families. He believes that research in the behavioral sciences is needed to learn how to effectively bridge the gap between knowing how people's eating, drinking and living habits affect their health, and actually changing those habits.

Dr. Richmond gained experience in public policy in health and education as the first director of Project Head Start in the Office of Economic Opportunity; later, as director of health affairs for OEO, he developed the national model for neighborhood health centers.

As the director of ADAMHA, Dr. Klerman brings to his new post a strong desire for "more attention to affective disorders" like those of drug abusers, on the part of mental health researchers, and for studies that will disentangle genetic from environmental causes in mental illness and in alcoholism. More data, he believes, are also needed to properly assess the benefits of community mental health centers and other forms of psycho-social intervention. On the issue of decriminalizing marijuana, he is reported to share the flexible stance of the Carter administration.

Dr. Klerman's background includes six years' experience as superintendent of the Erich Lindemann Mental Health Center, from 1970 to 1976. Prior to that, he served as director of the Connecticut Mental Health Center and associate professor of psychiatry at Yale University Medical School.

The ways we age

A better understanding of the physiology of aging is the goal of Dr. John Rowe, assistant professor of medicine at HMS and head of a recently created Gerontology Unit at the Beth Israel Hospital. Under a grant from the new National Institute on Aging of the National Institutes of Health, Dr. Rowe and his colleagues will try "to learn more about how a healthy old person differs from a healthy young person, and to study how an elderly person's response to a disease or treatment differs from his young counterpart."

According to Dr. Rowe, "many diseases with well recognized symptoms in young or middle-aged adults present with different symptoms in the aged." The training in medical schools today, he says, focuses on the pathology of the young or middle-aged patient, producing physicians ill prepared to care for elderly patients, who occupy a third of all hospital beds, and whose percentage in the population is rapidly increasing.

The Beth Israel Gerontology Unit is initiating research in several areas, including the impact of age on metabolic and endocrine adaptive processes, and the determination of age-related physiological variables which can help physicians distinguish between normal and abnormal processes in the elderly. Other areas of investigation will be the influence of age on the way symptoms present in certain diseases and their response to therapy, and age-related changes in the nervous system.

Future gerontological research, in Dr. Rowe's view, must deal also with the problem of medications. "The elderly may be the most over-medicated group in the country," he comments. "They may also be the most susceptible to side effects of drugs, especially since we do not know very much about the way chemical alterations in the body that result from aging interact with various drugs." Methods must be found, he stresses, to adjust drug dosages to special needs of the aging body.

Dr. Rowe brings to this work a very definite perspective on the human life cycle. Much previous research, he believes, has suffered from the erroneous assumption that people grow and develop until about age twenty, and then remain relatively stable physiologically before entering a steep decline after sixty. "In fact, the life cycle is one of growth and development until about the age of thirty, which is followed by a gradual decline until death." Trying to get away from the prevalent view of old age as a sort of disease that suddenly overtakes people, the gerontology unit will approach aging positively, as a stage in the life cycle, with its own possibilities for health and vitality, as well as its own manifestations of illness.

Lub-dub, lub-dub . . .

New ways of treating patients with acute myocardial infarction will be the focus of a four-year clinical study to be coordinated at Harvard Medical School, and carried out at five hospitals around the country with funding from the National Heart, Lung and Blood Institute of the National Institutes of Health. Two substances, the drug propanolol and the enzyme hyaluronidase, already proven to limit the extent of heart muscle tissue death when administered promptly, will now be further evaluated for their long-term effects on patient survival and health, heart function, and the incidence of pain. Participating in what will be known as the MILAS study (Multicenter Investigation of Limitation of Infarct Size) are the Peter Bent Brigham and Massachusetts General hospitals, where the pilot clinical trials

were conducted, joined by Barnes Hospital in St. Louis, The University of Texas at Dallas Southwestern Medical Center, and the Medical Center Hospital of Vermont in Burlington.

"The stakes in this new study are very high," notes principal investigator Eugene Braunwald, M.D. "There are 600,000 new cases of cardiac infarction a year." Now chief of medicine at the Brigham and Hersey Professor of the Theory and Practice of Physic at HMS, Dr. Braunwald began investigating heart tissue survival in 1968, when he was chairman of medicine at the University of California Medical School at La Jolla. Working first with animals and later with human patients, his research group confirmed his expectation that "the tissue is not 'condemned to death' immediately; we can salvage large parts of it if we move quickly." For the purpose of the new study, "quickly" will be defined as within eighteen hours after the onset of the infarction.

Working with Dr. Braunwald in the MILAS study are Drs. Herman Gold and William Strauss at the MGH; and at the Brigham, Dr. Peter Maroko, who had worked on the original research at La Jolla, Joseph Alpert '69, and Dr. James Muller. Coordinating the other outposts are Drs. Robert Roberts in St. Louis, L. David Hillis in Dallas, and Daniel S. Raabe in Burlington. Patient trials at the five hospitals are scheduled to begin by June 1978; others may join later.

Medearis directs MGH pediatric unit

Donald N. Medearis, Jr. '53 is the new head of the children's service at the Massachusetts General Hospital, successor to Nathan B. Talbot '36. He became chief of the Burnham Pediatric Unit, as well as Charles R. Wilder Professor of Pediatrics, on July 1.
Dr. Medearis comes to the MGH from Case Western Reserve, where he was co-chairman of the pediatrics department and director of pediatrics at Cleveland Metropolitan General Hospital. His first faculty post following residency was at Johns Hopkins, after which he went to the University of Pittsburgh School of Medicine as professor and chairman of pediatrics, later becoming dean. He was also medical director of the Children's Hospital of Pittsburgh.

In his research in medical virology, Dr. Medearis has focused on cytomegalovirus infection, which can be transmitted by a mother to the fetus, causing the child to be born deaf or mentally retarded. He sees retardation as the most serious problem confronting pediatricians today. As head of the MGH children's service, Dr. Medearis is trying to establish closer working relationships with the other specialties, and enlist their expertise in the care of infants and children. Within his department, too, he believes in a multidisciplinary approach, bringing together the special insights and perspectives of social workers, nurses and psychologists, as well as pediatricians, to find better ways of responding to children's needs and illnesses.

Preventive care . . . on the air

Body Politics is the name of a new television series designed to encourage Americans to practice preventive care of their own health, rather than going to the doctor when it is too late. After premiering on Boston's WBZ-TV this fall at 6:15 a.m., the ten-week series will travel to other local stations, including San Francisco's KPIX, Baltimore's WJZ, KYW in Philadelphia, and KDKA in Pittsburgh. Produced by Westinghouse Broadcasting Company and syndicated by Commonweal Productions, a public interest programming organization, the shows are also available for use by schools, hospitals, medical schools, and community groups.

Several alumni are among the health advocates, consumers and professionals appearing on the show. Richard Egdahl '50, director of Boston University's Medical Center, explains the value of a second opinion before surgery, while Jonathan Fielding '69, Massachusetts Commissioner of Public Health, talks about the use of child restraints to reduce highway fatalities, and Mitchell Rabkin '55, director of the Beth Israel Hospital, discusses patients' right of access to their medical records.

The producer and host of *Body Politics* is James L. Mason, M.P.H., who currently holds a joint appointment as instructor in the department of public health and community dentistry at Boston University School of Graduate Dentistry, and in the department of sociomedical sciences and community medicine at Boston University Medical School. Requests for tapes of the programs and other inquiries should be addressed to Body Politics, Box 12, Arlington Heights, Arlington, Massachusetts 02175.

Medicine at Harvard: the first three hundred years

by George E. Gifford, Jr.

American medical history tends to fall into clearly defined categories. There are the biographies of medical figures, the reports of disease entities, tales of medical practice and research of a certain era or geographic location, accounts of the course of medical education, and institutional histories of foundations, societies and medical schools.

The histories of medical schools have not always been written by professional historians, bound by detachment and objectivity; they were compiled by dedicated, rather partisan, professors or deans or alumni. Notable examples of such books include the *Historical Sketch of the University of Maryland School of Medicine 1807-1890* (1891) by Eugene Fauntleroy Cordell, who was a member of the class of 1868 and later became the school's dean. *A History of Tufts College Medical School Prepared for its Semi-Centennial 1893-1943* (1943) was authored by Benjamin Spector, a beloved professor of anatomy and of the history of medicine for many years.

Some histories of medical schools have been written by local historians. Within a five year period, from 1945 to 1950, Frederick Clayton Waite of Vermont wrote about three of the state's medical schools of the nineteenth century. The most unusual twist in historical projects of this sort have been works authored by committee. This would appear to be a more current innovation, as in *To Each His Farthest Star, University of Rochester Medical Center 1925-1975,* which was published in 1975.

Many of the older histories are written in the style of family genealogies; some sound like chapters of the Old Testament where——— begat———. They ignore the existence of the larger intense social forces — intellectual, financial, academic, religious — that a medical school invariably represents. Medical schools are depicted as self-perpetuating entities guided by superhuman beings in a social vacuum. Nevertheless, many of these tomes contain all that is preserved of these institutions, and therefore constitute an invaluable resource.

There are notable exceptions to this kind of banal format: Alan M. Chesney's three volume *The Johns Hopkins Hospital and the Johns Hopkins University School of Medicine; A Chronicle* (1943), George W. Corner's superlative *Two Centuries of Medicine, A History of the School of Medicine, University of Pennsylvania* (1965), and the short, exemplary *Dartmouth Medical School — The First 175 Years* (1973) by Carleton Chapman, HMS '41. All three authors shared the clinician's vantage point and were motivated by a dynamic involvement with their institutions. As well as being sensitive to the minutiae, all three books convey a broad view of American medicine in a social context.

The first history of the Harvard Medical School, like most of its early counterparts, was written by an alumnus, Thomas Francis Harrington, class of 1888. Following the family genealogy genre, nearly two hundred pages are devoted to a roster of alumni, which is accompanied by others of benefactors and teachers. This thick, three volume, maddeningly indexless history nevertheless contains information not found in any other sources.

In the early 1960s, Dean Sidney Burwell began a history of the Harvard Medical School, but ill health prevented him from finishing it. Although not a history of the Harvard Medical School per se, Jean Alonzo Curran (HMS '21)'s *Founders of the Harvard School of Public Health with Biographical Notes 1909-1946,* reveals much of what was going on in the Harvard Medical School academic community. To his credit, Dr. Curran enlivened his work with sketches of the more picturesque individuals.

The late Henry K. Beecher '32, the Henry Isaiah Dorr Professor of Research in Anesthesia, Emeritus at HMS, Chief of the Division of Anesthesia at Massachusetts General Hospital, began to research a history of the Harvard Medical School in 1970 by sending questionnaires to mine the cumulative body of historical knowledge of HMS faculty members. He worked diligently and faithfully on this project until he became ill. Realizing that he would be unable to complete the work alone, he asked his classmate, Mark D. Altschule to help prepare the book for publication. By reorganizing and substituting new material, Dr. Altschule succeeded in editing the text from twelve hundred to slightly more than six hundred pages. *Medicine at Harvard: The First Three Hundred Years* is divided into four major parts: The Earliest Stages; The Eliot Years, 1869-1909; The Great White Quadrangle: From 1906; and Noncurricular Factors in the Growth of the School.

"We are a business-doing people.
We are new.
We have, as it were,
just landed on these
uncultivated shores;
there is a vast deal
to be done;
and he who will
not be doing must be
set down as a drone."

— James Jackson to James Jackson, Jr., about 1830, advising him to leave off research. (p. 18)

In "The Earliest Stages," Beecher and Altschule trace the colonial medical background and Harvard medicine up to 1869. Those old familiar faces become alive — the idealistic John Warren, his proprietous son John Collins Warren, the crotchety and brilliant Benjamin Waterhouse, the amiable James Jackson, and the jewel in Harvard's crown, Oliver Wendell Holmes. These men and the growth of the School are presented with an appreciation of the larger picture of the American medical experience at that time. But, as the authors conclude, the Harvard Medical School "was run as if it were a private club."

"Does Mr. Lowell know anything
about medical education?
Or Reverend Putnam?
Or Judge Bigelow?
Why, Mr. Crowninshield
carries a horse-chestnut
in his pocket
to keep off rheumatism!
Is the new medical education
to be best directed
by a man who carries
horse-chestnuts in his pocket
to cure rheumatism?"

— Henry Jacob Bigelow, professor of surgery, about 1870. (p. 88)

The second section, "The Eliot Years," sympathetically relates how President Charles Eliot reformed the Harvard Medical School. "The club was abolished by President Eliot when he established regulations governing student admission, attendance, and tuition fees as well as faculty salaries. Some of the faculty were appointed full time during his era, and the University came to have a controlling voice in their appointment."

"The medical students were
noticeably inferior in
bearing, manner,
and discipline
to the students of
other departments;
they are now indistinguishable
from other students."

— Charles William Eliot, president of Harvard, 1880. (p. 94)

The third and longest part, "The Great White Quadrangle," chronicles the events from 1906 to the 1964 resignation of Dean George Packer Berry. The modernization of the curriculum achieved by the Flexner Report and Dean David Edsall is thoroughly detailed. The emergence of an extensive premedical curriculum — medicine, surgery, pediatrics, preventive and social medicine, radiology, neurology, psychiatry, dermatology, anesthesiology, neurosurgery, orthopedic surgery, ophthalmology, otolaryngology, facial surgery, and obstetrics and gynecology

— characterized this period of Harvard's ascendancy. It is the one most living alumni can remember and they can judge for themselves the accuracy and depth of this beautifully presented account.

The final section, "Noncurricular Factors in the Growth of the School," branches out in three directions. "Special Groups of Students" deals with women, black and Jewish students. "Special Enterprises" gives the background of such offshoots as the Warren Anatomical Museum, the Harvard Cancer Commission and the Collis P. Huntington Memorial Hospital, and the Biophysical Laboratory. *Medicine at Harvard* concludes with "Associated Institutions," which considers the ways in which HMS dovetails with the Graduate School of Arts and Sciences, the Division of Medical Sciences, the affiliated teaching hospitals, the Francis A. Countway Library of Medicine and the Boston Medical Library.

The gist of the book is rendered in a masterful epilogue. This is not the "dry bones" reaction of the historian, but rather a "straight from the hip" conclusion that emphasizes the value of bedside teaching as well as the need for great leadership. Beecher and Altschule do not shy away from pungent criticism of more recent developments in the governance of the Medical School. "The marked changes in [Harvard Medical School's] policies under its last two deans have, however, removed it from the track it had followed so successfully since 1782 and have made its direction unpredictable."

How does *Medicine at Harvard* come off? It is a scholarly, readable, accurate history of the Harvard Medical School, of which Henry Beecher would have been and Mark Altschule can be justly proud. The book is decently illustrated and handsomely printed, and joyfully, includes a thorough index. It should be read by every alumnus/a, and by all who are interested in the diverse paths of American medicine. It joins that select group of histories of medical schools by Corner, Chapman, and Chesney; indeed, I think it is the best history of a medical school that has yet been written.

How the history was written

The view from the southeast corner of the fifth floor of the Countway Library is breathtaking — where else can one get a more spectacular vista of three hundred years of Harvard medicine? One shares the simultaneously mocking and reverent outlook of the occupant of the incunabula-filled corner room, Mark D. Altschule '32, who, after the death of his classmate, Henry K. Beecher, carried their co-authored volume to completion. When Altschule joined the effort, Beecher had compiled a 1200-page manuscript, exclusive of notes, in which he had accorded each discipline of medicine a separate chronological history, taking anatomy from 1782 to the present, then surgery, and so on. After being consulted, Altschule pointed out to Beecher that HMS rather got lost in the chronological-by-disciplines approach. Where were the eras that centered around great men? These could be the organizing principles of the book. Beecher was exhausted by terminal illness and asked Altschule to give it a try.

> *"Half of what we have taught you is wrong. Unfortunately, we do not know which half."*
>
> — *Sidney Burwell, Dean of HMS 1935-1949, speaking to a graduating class (p. 211)*

A race against time began: Altschule was determined that both authors agree on everything that came out of the manuscript or was put into it, and he hoped to have the hardcover book in Harry Beecher's hands before his death. The first objective was reached; but although Beecher read the completed manuscript, the second was missed by a year. Reorganization of the original draft eliminated about five hundred pages. The concept of eras made it necessary to relate HMS history to the history of medicine generally, and Altschule did this. Time did not permit re-researching Beecher's documentation or documenting Altschule's general medical history, and the book is not as carefully wrought as it would have been, had Beecher lived.

Of their collaboration, Altschule says, "The only disagreement that Harry and I had was about the nature of medicine. He thought that it was a philosophy, and he quoted St. Isidore of Seville who in the year 628 said, 'Medicine is a philosophy.' I think that medicine is a humanity which uses a certain amount of science, to be sure, but primarily concerns itself with human values. It is at all times, or should be, a transaction between two people, doctor and patient,

> *"There is a fundamental similarity between studying masses of anonymous molecules in their environment and masses of anonymous people in theirs."*
>
> — *The authors, concerning the shift from molecular biology to public health (1972) of Howard Hiatt, formerly professor of medicine at the Beth Israel and now dean of the School of Public Health. (p. 319)*

"I felt it was drawing me completely away from the mainstream of human activities and I felt that if I continued in it very much longer I might become a good scientist but not develop into a very good human being."

—Claude E. Welch, re an earlier incarnation as an organic chemist. (p. 342)

with or without subsidiaries. The basic scientists have come to look upon medicine as something involving nothing bigger than a molecule; as a physician, I know that medicine involves nothing smaller than a patient."

"The current overcommitment to basic science that has characterized the last two or three decades of medical teaching (and patient care) has produced a discontent in two important groups — patients and students."

—The authors. (p. 529)

A bigger and duller history may be written by a company of scholars, diligently comparing and revising, but our generation is the possessor of an account by two contemporaries, partisans and combatants, veterans of eighty-five man-years at HMS. Fortunately, we can also look forward to another new book whose documentation, littered on the kitchen table, forces Mark Altschule to take his meals standing up. It will tell how medicine has changed, from Napoleon's day to the present, and why; and best of all, it will tell what Altschule thinks is good and bad about it.

— George S. Richardson

How do you score on HMS lore?

1. "Harvard Medical School was founded three hundred years ago." True or false?
2. Who wrote "The Case Method of Teaching Systematic Medicine?" When was it published?
3. William Osler originated bedside teaching at Johns Hopkins, 1899-1904. True or false?
4. Who were the devil-may-care Bostonians who were ready, despite lack of funds, to proceed with buying twenty-three acres for the site of the Great White Quadrangle?
5. Harvard Medical School's reforms had begun forty years before the Flexner Report was published. True or false?
6. The first woman professor at HMS received her appointment under three limitations: she was not to enter the Harvard Club; she was not to participate in the Commencement Academic Procession; and she was not to expect professorial privilege in obtaining football tickets. Who was she?
7. Harvard's "Full-Time System" was established by whom and differed from that at Johns Hopkins in what vital aspect?
8. What dean of HMS showed that it was possible to integrate research, teaching, and the care of the patient?
9. What is the Dwight D. Eisenhower Scholarship Fund?

Answers

1. False. Harvard Medical School was founded 195 years ago (look out — a fund drive is coming!) but medicine at Harvard began 300 years ago.

2. Walter B. Cannon; Boston Medical and Surgical Journal 142:31-36 and 563-4, 1900. Cannon got the idea from a roommate who was a law student under Professor Langdell; Richard C. Cabot established it as a system. (pp. 52, 269)

3. "False!" say our authors; HMS was doing it in the 1850s. (p. 77)

4. John Collins Warren and Henry P. Bowditch in the 1890s. (p. 167)

5. True! "Charles William Eliot, President of Harvard University, labored with great success for forty-one years before the appearance of the Flexner Report to correct the inadequacies of medical education at Harvard and, by example, in all American medical schools. But his efforts had only local authority, and their effects were not widely recognized in the early years." (p. 176)

6. Dr. Alice Hamilton, appointed in 1919. (p. 196)

7. Dean David Linn Edsall, Dean of HMS, 1918-1935; a man could increase (double) his academic salary in private practice. (p. 200)

8. Dean Edsall, who did all three preeminently. (p. 205)

9. Established by HMS's first black professor, William A. Hinton, it memorializes his parents, Augustus and Maria Hinton, "who, although born in slavery and without formal education, nevertheless recognized and practiced not only the highest ideals in their personal conduct, but also the true democratic principle of equal opportunity for all, without regard to racial or religious origins or to economic or political status." The fund is "to be used in any department (of the University) by way of scholarship grants, prizes for scholarly treatises or other achievements, or otherwise." (p. 279)

James Ballard: one of a kind

Occasionally, one encounters an individual who endures and prospers along with the institution he or she diligently serves. Within a select circle, these people often become the mentors, valued for their erudition and sometimes peculiar charisma. They come to personify, and even transform, an institution, so that the two — individual and institution — merge nearly into one image. Boston seems always to have bred an assortment of talented men and women of modest beginnings who have found themselves attracted to the cultural and intellectual milieu of the educated class. Early in the twentieth century, when prominent Boston physicians gravitated to the elegant establishment at 8 The Fenway, the Boston Medical Library, they might have had the good fortune to become acquainted with the doyen of the BML — James Francis Ballard. He lived from 1878 to 1955 and made the BML his life's work from 1892 until his death — an extraordinary service of sixty-three years.

In 1900 James Ballard had advanced to the position of second assistant, prior to the move of the Boston Medical Library from its domain at No. 19 Boylston Place to 8 The Fenway in 1901.

James Ballard (never Jimmy) first appeared at the Boston Medical Library in knee britches, responding to a sign in a window, "Boy Wanted," in October of 1892. He started as an errand boy whose job was to deliver books to local physicians, among them distinguished men such as Oliver Wendell Holmes. A bright boy who was not schooled beyond the eighth grade, his life resembled an archetypical pattern — from errand boy to director of the Boston Medical Library in 1927. His focal position among an elite group of people compensated for his inferiority regarding his background, and he was far from being cowed in his relations with some of the rather supercilious individuals who frequented the BML.

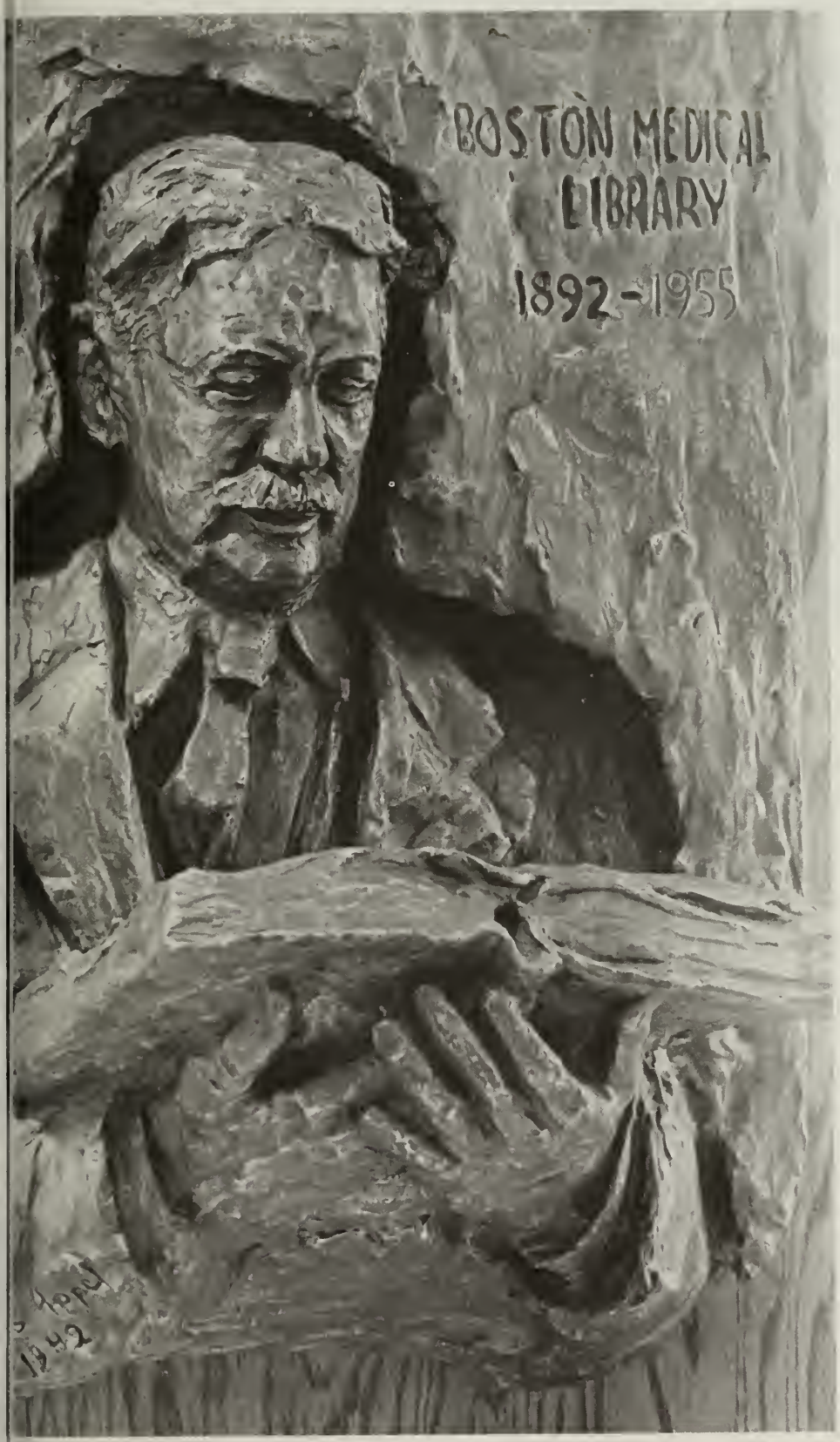
It is sobering to learn that while he lacked a formal education, Ballard authored *The Boston Medical Library Medical Classification,* which saw its third edition in 1948, as well as two other works of significance to medical bibliophiles: *A Catalogue of the Medical Incunabula Contained in the William Bullard Loan Collection* (Boston, privately printed, 1929) and *A Catalogue of the Medieval and Renaissance Manuscripts and Incunabula in the Boston Medical Library* (Boston, privately printed, 1944).

Ballard lived in the years that were ripe with the comings and goings of the medical literati of Boston — Harvey Cushing, William Osler, Arnold Klebs, Richard Cabot, Henry Viets and a host of other physicians became close friends and shared his interest in the rare books that elucidated the history and development of modern medicine. Ballard was a charter member of the Boston Medical History Club and served as its secretary (curator) from its inception in 1921.

The eulogy by Henry Viets in the *New England Journal of Medicine* described his singular, if slightly detached, manner:

He presumably knew more about old medical books than almost anyone living in his time . . . He was meticulous in the care of the valuable material entrusted to him, although careless about his personal appearance and often a little gruff in manner. When it came to the treasures in the Library, no one could have been a better custodian and guarded them more carefully, or handled them with more reverence. He came to symbolize the Library and ran it, of course, as a 'one man show' long after it might have become more standardized in form. He was what the book world would call a 'unicum,' one of a kind, who set a pattern that can never be duplicated. . . . He was always a little reserved and perhaps difficult to know well, but once the bridge was crossed, no one could have a finer friend or one with more enduring qualities.

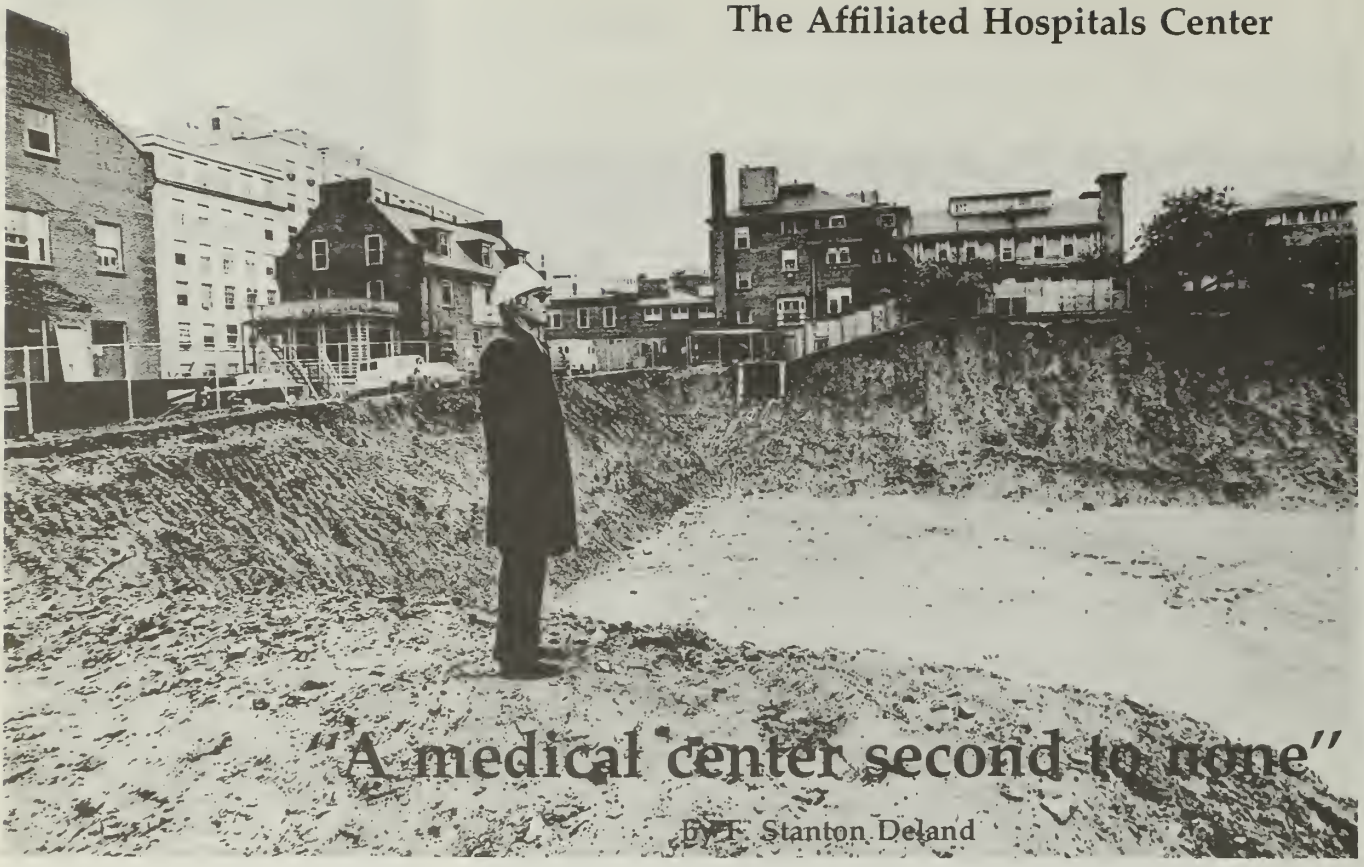
— George E. Gifford, Jr.



To celebrate James Ballard's fiftieth year with the Boston Medical Library in 1942, the well-known medical sculptor Doris Appel, who was also a friend, executed a bust of him, which he had hung in Holmes Hall and later in the Periodical Room at 8 The Fenway. With the move of the Boston Medical Library to the Countway Library in 1958, the sculpture was consigned to the basement, where it rested anonymously until a few years ago, when other Appel works became subject to considerable interest. In the spring of 1975 the Boston Museum of Science acquired her massive frieze, "American Medical History," and the following year, "The Hall of Medicine," which comprises twelve monumental figures in the history of medicine, was dedicated at the Boston University School of Medicine. Subsequently, the plaster cast of Ballard was retrieved and the trustees of the Boston Medical Library voted to have it cast in bronze to be hung, with all due ceremony, in the Countway. On October 27 a bronze portrait-plaque in high relief was unveiled in the auditorium. The inscription underneath reads:

James Francis Ballard
1878–1955
Director,
Boston Medical Library 1928–1955
His unique knowledge and dedicated service greatly enriched the Library's collection.

Doris Appel herself remembers James Ballard with great esteem, which she translated into her sculpture of him. "James Ballard was a special friend to me, always willing to help in my research of historical material for the biographical portraits of the figures in The Hall of Medicine . . . How else could I better express my gratitude than by feeling that a sculptured portrait of him belonged with his beloved books."



"A medical center second to none"

By F. Stanton Deland

It has been two years since the Affiliated broke ground and the Bulletin *covered the story leading up to that momentous event (Jan./Feb. 1976). In the following thirteen pages we juxtapose two articles that divulge more of the still-fascinating history of the AHC. The first is by F. Stanton Deland, president of the AHC; the second is by Howard Waitzkin '72, who coordinated the Medical School support group for community tenants of the Harvard-owned property that was originally planned as the hospital site. While the two articles present contrasting viewpoints, they were submitted to the Bulletin independently; neither was written in response to the other.*

F. Stanton Deland has been president of the AHC since 1963. He is a partner in the Boston law firm of Sherburne, Powers & Needham, and from 1972-75 was president of the Board of Overseers of Harvard University. The following article was originally a talk delivered to the Harvard Medical School Committee on Resources in June 1977.

The development of the Affiliated Hospitals Center has been a long, arduous process in which progress has not always been readily discernable. It was about twenty years ago that Dean George Packer Berry broached the idea of a new medical center to the Peter Bent Brigham, Robert Brigham, Boston Lying In and Children's hospitals, the Free Hospital for Women and the Massachusetts Eye and Ear Infirmary. In 1961 a joint planning group was formed, and in 1962 the Affiliated Hospitals Center came into being as a Massachusetts corporation, possessing a set of bylaws carefully designed by lawyers to confuse the layman and assure everlasting autonomy to each of the member hospitals.

In 1963 Dr. Robert Glaser was lured from Colorado to assume the presidency. He was warmly welcomed and given every assurance of cooperation excepting, of course, any authority. He prepared thoughtful plans and presented them with force and eloquence. He did receive authority to hire architects, the Chicago firm of Bertrand Goldberg Associates, but was able to accomplish little else, as hospital trustees and medical staffs jealously guarded their own turfs. Then in 1963 the deanship of Stanford Medical School beckoned, and Glaser departed from the scene. That same year Dean Berry reached retirement age and was succeeded by Dr. Robert Ebert.

Affairs of the Affiliated had reached such a low ebb that I was appointed Glaser's successor as president. One of my first moves was to visit Dr. Ebert at the MGH prior to his taking over the deanship. The enthusiasm of Bob Ebert for the Affiliated concept convinced me it was worthwhile to continue the struggle. In early 1966 a significant milestone was achieved with the merger of the Free Hospital for Women and the Lying-In into the Boston Hospital for Women — a sizeable chink in the armor of autonomy. It provided cheerful proof that men (and Women) of goodwill can surmount petty jealousies and

"In 1962 the Affiliated Hospitals Center came into being as a Massachusetts corporation possessing a set of bylaws carefully designed by lawyers to confuse the layman and assure everlasting autonomy to each of the member hospitals."

parochial attitudes if the cause is in the overall public interest.

Later in 1966 Ray Brown, director of hospital administration at Duke University, former chief administrator of the University of Chicago Clinics, and a man of national reputation, was invited to join the Affiliated. Brown was a practical, hard-headed man with a long history of successful administrative experience. He refused. We were, however, successful in persuading him to act as a consultant to find a way out of our morass. He came to Boston, interviewed trustees and members of the medical staffs of each of the hospitals, and submitted a proposal that would fold the Affiliated into the Peter Bent. It would create the role of executive vice president of the Affiliated, who would serve as the administrator of both the medical center and of the Peter Bent. The Peter Bent would contract with the other hospitals to build and operate the Center, a practical solution which centered authority but preserved some degree of outward autonomy.

Much too practical for the Affiliated! It was on the fifth fairway of a South Carolina golf course that the idea of a joint venture occurrred to me as a possible compromise. With the support of Dr. Sidney Lee, Dean Ebert's assistant, we managed to sell this idea to Brown; he agreed to leave Duke and come to Boston — to his later everlasting regret. In 1967 the Joint Venture came into being with Ray Brown as executive vice president.

The Joint Venture was comprised of the two Brighams and the Womens Hospital. Childrens had long since departed on its own way, and the Eye and Ear had decided that its neighbors, the MGH and the Charles Street Jail, were more attractive.

The first two years of Brown's regime witnessed a flurry of planning activity. The Joint Venture board, comprised of the three hospital presidents and the president of the Affiliated, worked harmoniously — for a time. The bed count shifted continuously as did the configuration of the building. An 800 bed hospital housed in three separate structures gave way to a central core with three wings, and a fourth reserved for Dr. Sidney Farber. The site moved from the east side to the west side of Francis Street as land acquisitions by Harvard and the Affiliated paved the way.

Ownership problems as to the central core arose. Who would be liable if Peter Bent, the poor relation, could not pay its bills — certainly not the endowments of its joint venturers! As the magnitude of the problems increased so did the bed count, which rose to 848. No one was satisfied with space allotments. Indeed, when the architect finished consulting with all the chiefs, the total of their space requirements — which they, of course, considered a bare minimum — was equivalent to three Prudential Insurance Company towers.

In the spring of 1969 the Affiliated and Harvard gave notice to some 180 neighborhood tenants to expect eviction within five years. This was admirably timed for the Harvard undergraduate "bust" which followed a few weeks later. Radical students seized upon a cause to further their strike.

Meanwhile, consultants hired by Brown reported that the AHC could not finance an 848 bed hospital. Brown thereupon presented plans for a 600 bed hospital, including only 230 for Peter Bent which would continue to operate 300 beds in its present structure; no one was happy. All efforts by Brown to achieve more centralized authority were unsuccessful and in the fall of 1969 he abruptly departed for the greener fields of Chicago. He was succeeded by his aide and former student, Richard Wittrup*, whom he had enticed to Boston from the University of Kentucky. What Ray Brown could not achieve by his aggressive leadership, his protegé was to accomplish through patience and diplomacy. All the chiefs of service were invited to join the Board's deliberations, and gradually consensus as to plans and joint programs began to evolve.

* *Mr. Wittrup has resigned as executive vice president of the Affiliated, effective December 31, 1977.*

"As the magnitude of the problems increased
so did the bed count, which rose to 848.
When the architect finished consulting with all the chiefs,
the total of their space requirements
was equivalent to three Prudential Insurance Company towers."

In 1971 a new certificate of need statute was adopted by the Massachusetts legislature. The Affiliated had previously obtained a certificate of need but was caught by the new statute, which had no grandfather clause. A new application for a 794 bed hospital was filed. The age of consumerism had arrived: taxpayer groups rose out of the neighborhood, stirred by student activists, to contest the new application. Lengthy negotiations with officials of the public health department and neighborhood groups ensued. Dean Ebert and I attended several neighborhood meetings, feeling as welcome as Jimmy Breslin at a Birch Society meeting. It was not an age of reason!

Largely at the initiative of Dr. Frank Austen, physician in chief at the Robert Brigham, a central planning committee with representation from the medical staffs of each hospital was formed, greatly improving and streamlining the planning process. Physicians could now thrash out and compromise their differences without getting involved at the board of trustee level. The three hospital presidents began to recognize the need for more centralized control. The hitherto dirty word "merger" began to be discussed — albeit cautiously behind closed doors. Simultaneously, the Public Health Council began to apply pressure for the issuance of a single license to a single entity. In December 1973 the three hospital boards voted to approve "in principle" a plan of merger conditioned upon the issuance of the certificate of need. This move, viewed by the opposition neighborhood as a sham, was in fact a giant step forward.

Meanwhile a brash new commissioner of health was pressuring the Affiliated to reduce the number of its beds. After a little bloodletting during which the good Dean brandished his scalpel, the bed count was further reduced to 688 — replacement of the existing bed total, but with internal adjustments.

In spite of all the planning problems, the fund raising campaign, interrupted by the student uprising, had come to a successful conclusion under the skillful leadership of the Affiliated's indomitable financial chairman, Thomas D. Cabot. Over sixteen million dollars was raised for a program then envisioned to cost about fifty to sixty million dollars.

The certificate of need application approached a climax in early 1974. Community groups were demanding participation in the hospital planning process. They wanted to limit the expansion of Harvard and the AHC into their neighborhood, plus financial support for an ambulatory care center of their own.

General excavation began in earnest with the advent of the warmer weather. The earth retaining system was partially installed by the end of May. By the end of July, both of these initial phases were complete.

To attain these ends they threatened legal action on environmental grounds. We were confident of winning in court but we could not afford the delay. The Affiliated was under the gun; delay would probably blow the merger plans apart and scuttle the Joint Venture for all time.

For once the commissioner, usually allied with the objectors, was anxious to cooperate. The deadline for decision on the application was April 30. The certificate of need law, however, was under attack in the legislature, and a denial of our application might put the whole legislation in peril. In the late hours of April 29 a Memorandum of Understanding was signed between the Affiliated and neighborhood representatives. The certificate of need was granted on April 30th.

On January 1, 1975 corporate merger of the three Joint Venturers was achieved and for the first time power, not merely desire, became vested in the Affiliated Hospitals Center, Inc. Each hospital became a division of the Affiliated. The trustees of the hospitals became overseers with responsibility for the operation of their own divisions. Each hospital has three of its trustees on the central Affiliated board of trustees, and final authority at long last resides in that body.

A feature of the merged corporation's bylaws was the inclusion on the board of trustees of representatives from the public; one to be nominated (not appointed) by the governor, one by the mayor and three by community groups, in addition to three members-at-large elected by the board itself, for a total of seventeen. Critics howled with dismay, but experience to date with our public trustees has justified their participation. They have been constructive and helpful. Moreover, they have perhaps inculcated the other trustees with a more acute awareness of responsibility to the immediate community.

Peace with the community was bought at a high price. The site moved back to the easterly side of Francis Street to the parking lot of the Peter Bent Brigham. Harvard agreed to finance construction of some 800 units of housing on the old Convent site on Huntington Avenue — planned as the original site of the AHC. To permit construction on the parking lot, we had to purchase the Good Samaritan property from Children's in a three way deal.

Bertrand Goldberg's final plan, about No. 87, was approved — now reduced to a single thirteen story tower in a four leaf clover form, sitting atop laboratory and service facilities, three floors of which are below ground. Though smaller in size, its cost had been inflated to approximately 130 million dollars. Such a staggering figure seemed beyond our capabilities; it appeared that construction would have to be financed in two stages. In a money saving gamble we broke ground in December 1975 at a ceremony marked with neighborhood demonstrations designed to keep us alert to their continuing demands. The Memorandum of Understanding of April 29 was supposed to be translated into a formal agreement, but the composition of neighborhood committees kept changing and the demands kept increasing.

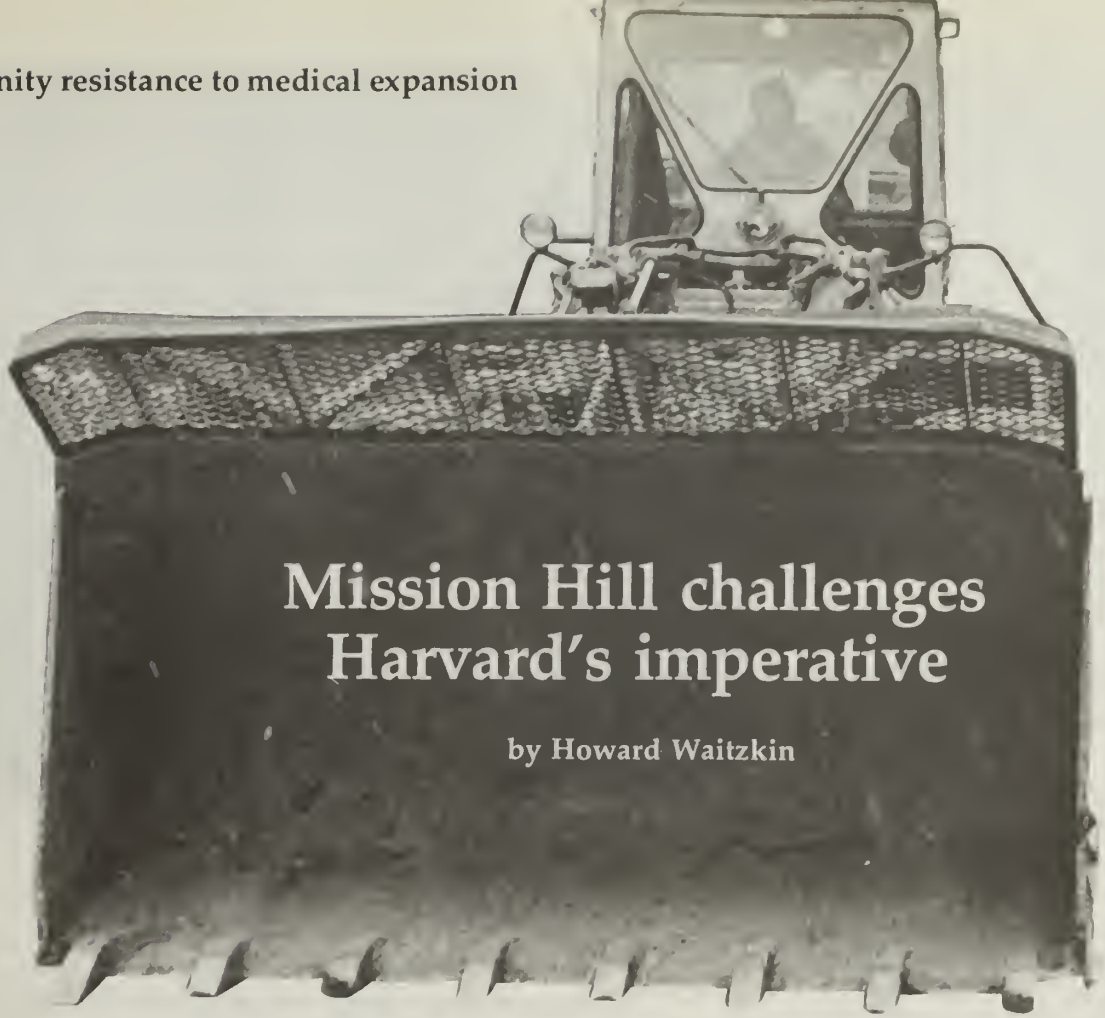
"Critics howled with dismay,
but experience to date with our public trustees
has justified their participation.
They have perhaps inculcated the other trustees
with a more acute awareness
of responsibility to the immediate community."

The bicentennial year was memorable for many things in Boston — tall ships and Queen Elizabeth to some — but to the Affiliated it was the year of achievement. After agonizing negotiations, we received final approval of plans from both federal and state authorities. A construction management contract with a guaranteed maximum price was signed with Turner Construction Company — in time to save three million dollars of federal Hill-Burton funds.

Right in our backyard: the view in September shows that approximately one-third of the "minus two level" structural slab and columns, in addition to the tower crane, were at the ready. Next came the installation of forms for pouring the "minus one level" slab. At present, construction workers have reached the ground floor.

There remained the overwhelming problem of how to finance the project. Professional fund raisers advised us to limit a second campaign to a realistic twelve million dollars. Construction estimates highlighted the fact that to build in two phases would increase the total cost by at least twelve million and probably more. Thus it appeared that to build in phases would wipe out the results of a fund raising campaign, and so under the leadership of our treasurer, Ephron Catlin — freshly retired from The First National Bank of Boston — and infused with his enthusiasm, we set out to borrow 94.6 million dollars. The strangest part of this undertaking was the novel experience of suddenly being wooed by competitive financial interests after having endured years of skepticism as to our survival.

In December 1976 we concluded the placement of 94.6 million dollars in mortgage bonds, guaranteed by the Government National Mortgage Association, to climax the most eventful year in our stormy history. The financing thus assured, construction is now underway in earnest. Skeptics still shake their heads in disbelief over the largest federal financing of hospital construction in history. This is not to say that life is easy — that is not the Affiliated way! The agreement with the community was finally signed in the spring of 1977. Relations have greatly improved and there is a better understanding on both sides. Many problems remain to be solved and there will be more bloodletting among the medical staffs, but enthusiasm is high. If luck is running our way, in five years we will finally witness the realization of our dreams (sometimes nightmares): a medical center second to none.



Mission Hill challenges Harvard's imperative

by Howard Waitzkin

Howard Waitzkin '72 lives in Mission Hill and is currently senior resident in medicine at Massachusetts General Hospital. While at HMS he was involved in many of the events described in his article. He took his internship and junior residency in medicine at Stanford University Affiliated Hospitals, after which he worked with the United Farm Workers in California as a primary care physician. For the last two years he taught at the University of Vermont as associate professor of sociology and social medicine.

This article uses materials that appeared previously in Society *(vol. 14, no. 2, January-February 1977, pp. 31-35) and* Science for the People *(vol. 9, no. 2, March-April 1977, pp. 22-23, 28-39); Transaction, Inc., and Science for the People kindly gave permission for the use of these materials in this edited version. The article in* Science for the People *contains a more detailed political analysis and debate concerning the Mission Hill struggle; it also presents references on medical expansion and community conflict.*

Uncontrolled medical expansion is threatening to eliminate many of our urban residential areas. Conflicts between expanding health institutions and local communities have occurred during the last decade in Boston, New York, Newark, San Francisco, Oklahoma City, Washington, Chicago, and other cities. In addition to community disruption and often extinction, the proliferation of medical centers — when analyzed in terms of their overall costs — has led several health economists to advocate a five year freeze on all new hospital construction or expansion. Paradoxically, at the same time that private hospitals and health facilities continue to expand, we face cutbacks in urgently needed public hospitals and services in both rural and urban areas.

To identify this problem is not to argue against good health care or the institutions required to provide it, but only to insure that these facilities be truly needed, that they provide easily accessible services, and that they be planned in a manner which causes minimal disruption to their host communities. Until recently it has been difficult to argue against hospital expansion or new construction. Most people have believed that there is a need for more medical care and that this need justifies new hospitals. Currently, however, this belief is meeting four lines of criticism: (1) that unrestricted expansion leads to unnecessary duplication and overlap of facilities in certain geographical areas and underservice in other areas; (2) that unused hospital beds ("overbedding") have led to a vast increase in hospital costs, and that the benefits of new hospitals therefore do not justify their costs; (3) that medical expansion does not reflect the health care needs of all segments of the population, but rather the concrete political and economic interests of the people who control medical centers; and (4) that more health services do not necessarily lead to better health, and that we should renew emphasis on self-care.

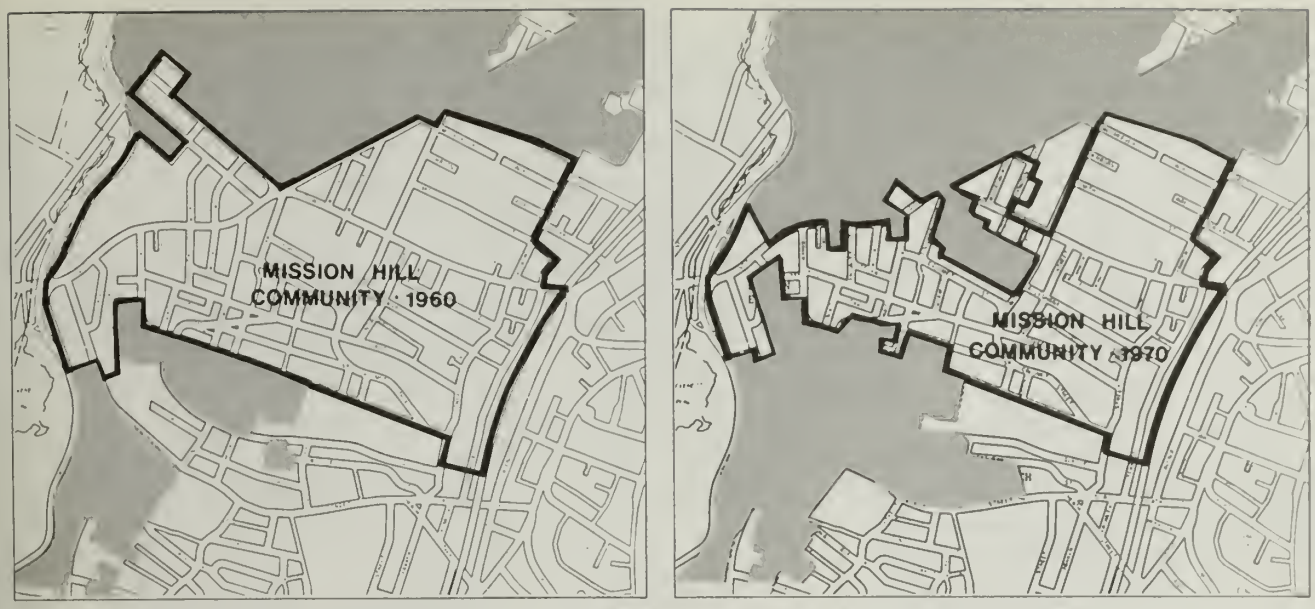
"Those who make decisions about institutional expansion often do not comprehend how crucial urban neighborhoods are to the people who live there."

The human costs are high when hospitals and other institutions expand at the expense of residential neighborhoods. During the past twenty years, urban renewal has removed thousands of people from their homes, replacing them with hospitals, office buildings, highways, and parking lots. Those who make decisions about institutional expansion often do not comprehend how crucial urban neighborhoods are to the people who live there. For professionals and other high-income individuals, geographical mobility is a comfortable part of life — and often related to career advancement. Urban working class families show more residential stability, satisfaction with their community, and strong social networks. When working class people lose their homes because of urban redevelopment, they generally suffer a deep and lasting grief that comes as much from the loss of their close-knit relationships as from the destruction of their homes.

Between 1960 and 1970 institutional expansion threatened to destroy the residential community that adjoins Harvard Medical School. After the announcement of construction plans for the Affiliated Hospitals Center, the resistance of Mission Hill residents crystallized around the impending loss of homes, coupled with the perception that the Affiliated had no plans for the kinds of health services — particularly outpatient care — that would benefit the community directly. By taking a strong stand, over a period of eight years, local residents succeeded in making the planning process a more balanced one, that took their needs into account.

Since its construction in 1899 the Mission Hill neighborhood had been composed of white Irish Catholics and Germans and a smaller number of black and Spanish-speaking families. Most people in the community were of moderate means, holding low- to middle-income jobs in manual trades or small businesses. The composition of the neighborhood had remained fairly stable. Most of the homes were two- and three-family dwellings in which the owner generally lived on one floor. Many people had grown up in the neighborhood and had set up households near their relatives and friends.

Beginning in 1964 Harvard's real estate agents bought houses in Mission Hill and gave priority in rental policies to transients (students, hippies, and young staff members at the hospitals) instead of families. Rents increased, and poor maintenance practices allowed the physical deterioration of the properties. Families who had lived in the neighborhood for many years found it difficult to remain. When Harvard announced its plans for the new hospital complex in 1968, residents received eviction notices stating that 182 apartments would be vacated and torn down by 1971. Officials of Harvard and the AHC offered no clear explanation of why the new hospital needed to be built on land occupied by housing, rather than on other nearby empty land owned by Harvard, nor did they have any concrete plans for relocation housing.



Key: Non-community institutional ownership ▢ Boundary of Mission Hill community ownership ▬

"The resistance of Mission Hill residents crystallized around the impending loss of homes, coupled with the perception that the Affiliated had no plans for the kinds of health services that would benefit the community directly."

The student strike at Harvard in 1969 publicized the threat to the neighborhood. The students demanded cancelation of the eviction notices and a promise not to destroy any housing. During the strike student organizers met with community residents who gradually decided to form a tenants' union, the Roxbury Tenants of Harvard Association. By the end of 1969 the group gave Harvard a petition affirming the tenants' desire to remain in their homes and requesting a change of the new hospital's location.

In response to the student strike, Harvard announced its decision to build 1100 units of new housing, part of which would accommodate residents displaced by the AHC. The financing of the project remained vague. Critics questioned whether appropriate apartments could be constructed for the large families who lived in the neighborhood. Before the announcement about new housing, university officials did not talk with tenants to learn about their perceived housing needs, or to obtain their participation in planning.

After the decision was announced, the University did set up several committees involving tenants, students, and health workers, but for at least an entire year the committees remained powerless to affect either hospital expansion or housing policies. Actual decision-making power stayed in the hands of the Harvard Corporation and high level administrators.

Frustrated by a lack of progress, tenants and their supporters then turned to more aggressive tactics. Community residents worked with student organizers in door-to-door canvassing. Frequent meetings took place in people's homes and at the local church. A leadership group emerged. The leaders, who numbered about ten, were of mixed ages, had families, and were long-term residents of the neighborhood. They came from different ethnic and racial backgrounds but generally similar economic positions. None of the leaders had been politically active prior to the expansion conflict; all had deep attachments to the community.

Gradually Roxbury Tenants of Harvard gained more members and emerged as a durable tenants' association. Mem-

bership eventually included most families in the neighborhood. Monthly meetings regularly have attracted forty to eighty members. Each year the membership has elected officers and board members who have worked together on specific strategies, negotiations, and organizing efforts. Although some officers and board members have been reelected each year, new people also have assumed leadership positions as the organization has gained strength. Student organizers gradually took much less initiative.

During late 1969, Roxbury Tenants of Harvard demanded direct negotiations with the Harvard Corporation and sent delegations to the corporation and to Dean Ebert. Together with student and faculty supporters in Cambridge and at the Medical School, tenants organized three nonviolent demonstrations and a "mill-in" at the dean's office involving more than one hundred participants. The demonstrators asked that Dean Ebert visit the neighborhood to inspect the deteriorating housing. After a delay of several weeks he toured the community with a group of tenants. The community also sponsored a city council public hearing in the local church. Newspapers, radio, and television stations publicized the demonstrations, the tour, and the hearing.

These events were the turning point. The University did not change its policies until the tenants' association, with supporters among the faculty and student body, showed a willingness to disrupt university business and an ability to attract attention in the public media. The Harvard administration, headed by newly-appointed President Bok, became convinced that the tenants' commitment and power base were strong enough that they had to be taken seriously.

Between 1970 and 1975, tenants obtained written agreements that responded to their needs:

Direct negotiations. The Harvard Corporation assigned one of its members and a staff person to take responsibility for negotiations with the tenants. In general, the Corporation has honored agreements reached between Roxbury Tenants of Harvard and these negotiators.

Rent freeze. The Corporation agreed to roll back and freeze rents at their 1969 level. In addition, the Corporation guaranteed that all future rent increases would be subject to the approval of Roxbury Tenants of Harvard.

Maintenance. By 1972, Harvard's real estate agent made repairs that brought the housing units up to the safety standards of the Boston Housing Code in most respects. At the tenants' instigation Harvard also began a program of housing rehabilitation, funded by the University.

Tenant-landlord relations. Rental priority was given to families who wanted to remain in the neighborhood. Vacant apartments were rented again as soon as possible. A real estate office was opened in the neighborhood, so that problems could be settled promptly. Because members of the tenants' association have participated actively in rental practices, the community has overcome pressures that discouraged families from staying in the area. As a result, the composition of the neighborhood again has stabilized.

"The University did not change its policies until the tenants' association, with supporters among the faculty and student body, showed a willingness to disrupt university business and an ability to attract attention in the public media."

Guarantees preventing eviction. In 1971, after a long series of negotiations, the Harvard Corporation promised in writing that no tenants could be evicted until suitable relocation housing was available and was approved by the tenants' association. This agreement guaranteed that residents would not be displaced from their homes without concrete relocation plans acceptable to the entire community. Most of the original buildings will remain intact.

New housing. Early in 1975, the tenants' association and Harvard finalized agreements concerning a new, tenant-controlled, mixed-income housing development, Mission Park. Roxbury Tenants of Harvard is a legal co-developer and has control over architectural plans, rental policies, and maintenance. Groundbreaking took place in October 1975. Many of the 774

Clockwise from top: Community residents join administrators from Harvard and the construction company, George B. H. Macomber Co., at the October 1975 groundbreaking ceremonies for Mission Park; one of the Harvard-owned houses before and after rehabilitation; high- and low-rise dwellings go up side by side at Mission Park

"Through community organizing and concerted political action, Mission Hill residents succeeded in both protecting the stability of their neighborhood and obtaining better health services."

Neighborhood residents gather at the dedication ceremonies for Mission Park.

Mission Park, seen from the southwest. The new ove parking garage. The four high- and mid-rise towe a community organizing.

new units will be located in low-rise townhouses with three to four bedrooms which will provide housing for large families currently living in the community. Smaller units also will be available for elderly persons, students and workers in the medical area. Residents are aware of the potential problems of community-controlled housing, but are committed to this goal as one means to stabilize the neighborhood.

During the same period that Roxbury Tenants of Harvard worked to provide for the neighborhood's housing needs, the Mission Hill Health Movement struggled to insure attention to community health needs in the new Affiliated Hospitals Center. Three areas of new legislation provided opportunities for residents to influence the planning process.

Certificate of need. The Massachusetts legislature passed laws in 1971 and 1972 requiring that the state Department of Public Health issue a certificate of need for any hospital expansion or new construction. As in other states, the laws' main goal was to help control the costs of health care by avoiding duplication and overlap.

Comprehensive health planning. A second area of legislation impinging on the AHC centered on the federal "Partnership for Health" Act of 1966. This act helped establish comprehensive health planning agencies on a regional and local level throughout the country. In Massachusetts, three of these agencies were involved in reviewing the AHC's certificate of need application.

Environmental impact. Another area of legislation affecting hospital construction was the Massachusetts Environmental Impact Law, which took effect in 1973, requiring that the evaluation of certificate of need applications include consideration of impact on the environment.

Laws that require comprehensive planning, in health care as well as other areas, seldom apply abstract standards of rationality. Planning is a political process, and planning laws often have effects that are more symbolic than real. For instance, expanding institutions can hire staff members who write justifying documents and maintain close contact with planning and regulatory agencies. Communities generally do not have money to hire staff people to do this work. Time and energy spent on the planning process most often are the voluntary contributions of local residents. This asymmetry of resources and staff usually favors large institutions in planning; as a result, local communities seldom have benefited from planning laws.

Residents of Mission Hill understood the largely political nature of the planning process. They doubted that the Department of Public Health would deny the AHC's certificate of need application outright. On the other hand, community residents realized that the

will include tennis and basketball courts, a playground, swimming pool, and
d after three students and a senior citizen from the neighborhood who were active in

application procedure provided a political lever by which they could postpone and reshape the AHC's plans so that the community's needs for housing and adequate medical care would be met.

The controversy over the AHC's certificate of need consumed over three years and considerable energy from community groups, comprehensive health planning agencies, and hospital staff; it resulted in several major changes in plans and programs.

Site and design. The AHC moved its site to a parking lot of the Peter Bent Brigham Hospital, where housing would not be affected. The original design called for a three-tower structure that would have extended over about two square blocks of space. The Mission Hill Health Movement strongly criticized this design. Current plans propose a single tower, with reduced research space and parking located away from the site.

Number of beds. The law required a detailed analysis of the need for new hospital beds. Eventually, the Department of Public Health approved 680 beds for the new facility — eight fewer than the total contained in the three hospitals and 110 fewer than the AHC initially requested.

Organizational structure and governance. After criticism from the community and planning agencies, the hospitals agreed to a formal corporate and clinical merger. Mainly through the Mission Hill Health Movement, the community also demanded positions on the governing board. The planning agencies supported this demand. Ultimately the AHC promised direct representation on the board through elections in the "host community."

Community health services. The certificate of need struggle led to a firmer commitment to walk-in care. In 1973 the AHC proposed for the first time a unified ambulatory care center serving the local community. The AHC also agreed that a community-controlled board would make policy for the ambulatory care center.

A new threat

Despite the relative success of Mission Hill residents in altering the course of institutional growth, plans for further expansion now threaten a health hazard, as well as further erosion of the community's residential character. The Harvard-controlled Medical Area Service Corporation (MASCO) plans to build a power plant on Francis Street to provide the AHC and other buildings with electricity, heat and chillled water. This enormous oil-burning facility, adjacent to housing and patient care facilities, would add greatly to noise and air pollution. Although hearings by the Boston Redevelopment Authority and the Department of Environmental Protection are still in progress, MASCO has been permitted to begin laying the foundations.

Many Mission Hill residents are convinced that the power plant is just the beginning of a new thrust of institutional expansion. A group concerned about pollution from the plant also has formed in Brookline. People interested in taking part in continuing efforts to save the neighborhood can get more information by contacting me at 51 Pontiac Street, Roxbury, Massachusetts 02120. — H.W.

"In struggling against medical expansion, community residents have realized that doctors and other professionals hold no special knowledge of the public good."

Through community organizing and concerted political action, Mission Hill residents succeeded in both protecting the stability of their neighborhood and obtaining better health services. People who live in the community have had a profound impact on their own destinies and on the institutions that affect them. This is a rare achievement, and it has brought changes in people's thinking as well as in their surroundings.

When the struggle began in 1969, most residents wanted to remain in their homes; however, they doubted their ability to win a conflict against such a powerful and wealthy institution. They had seen similar families displaced by Government Center in Boston's West End, by highway construction in various parts of Boston, and by other urban renewal projects. Initially people were skeptical that they could be successful. Now residents no longer feel powerless; they have participated in a series of concrete achievements. People have developed pride in the community and a sense of personal efficacy that results from the day-to-day experience of mutual support.

People in Mission Hill no longer uncritically accept the ideology which teaches that those who control institutions know what is best for society. In struggling against medical expansion, community residents have realized that doctors and other professionals hold no special knowledge of the public good and have their own private interests as well. They learned that a series of claims made by hospital officials — the importance of a site that would destroy housing, the need for several towers instead of one structure, the new hospital's contribution to local health services when there were no firm plans for an ambulatory care center — were unfounded.

Another powerful ideological pattern is also losing its hold. One of the injuries of social class in the United States is the subtle notion that class position is one's own responsibility. The belief is that if one is not upwardly mobile economically, it is one's own fault, despite evidence that there is little mobility across major class boundaries in the United States. Similarly, the external forces that affect people's lives assume an aura of individual responsibility. If a person had more ability or worked harder, according to this view, he or she could live in the suburbs and would not be subjected to urban redevelopment projects. People have tended to react to the destruction of their neighborhoods with passive resignation, as though the loss of a home is part of the buffeting in life that they somehow deserve.

These related ideological patterns — that those in power know what is best and that misfortunes are one's own fault — have been important factors in the passivity with which many communities have accepted urban redevelopment and institutional expansion. But both patterns are weakening. People who live in cities will no longer accept uncritically the claims of medical centers, universities and other large institutions for land, finances, or popular support.

Well planned medical centers need not eliminate any of our urban residential areas. Most community residents affected by medical expansion agree that adequate health facilities are needed, that existing facilities often must be improved, and that sometimes this situation means more space. But they also believe that an open planning process, with full identification of the interests involved and accurate information available to all, is desirable.

The planning process — an inherently political process — can lead to satisfactory results for those people most affected. Community-institutional conflict can lead to stronger communities, more responsive health institutions, and exciting opportunities for progressive change.

Sir William Osler's better half

by Marshall N. Fulton

When I entered Oxford as a medical student in the fall of 1920, the University was getting back towards normal after World War I, and many veterans were still in residence. Sir William Osler had died the preceding December. Lady Grace Osler, though deeply saddened by the double loss of both Sir William and their son, Revere, had made it clear that her home was still to be known as "The Open Arms." The great task that now loomed was the cataloguing of Osler's books. Wilder Penfield was in residence for his last term. Archie Malloch, then on a fellowship at Bart's Hospital in London, came regularly to Norham Gardens each weekend, adding cheer, good humor and spice to any gathering there. Soon to arrive from Geneva was Billy Francis, who would undertake the major task of cataloguing the books; and but a short time later, his daughter, Marian, was born, to add happy excitement to the Osler household. John Fulton's advent at Magdalen was but a few months off. Professor Charles Sherrington was active as the head of physiology. There was plenty of color aboard, even if Oxford had not won the boat race for several years.

Marshall N. Fulton, M.D. was a Rhodes Scholar at Oxford from 1920 to 1923. He graduated from Johns Hopkins Medical School in 1925, and was medical house officer and resident physician at the Peter Bent Brigham Hospital under the tutelage of Harvey Cushing '95. He was director of the Department of Medicine Laboratory at HMS from 1932 to 1936, and continued to serve at the Brigham and teach at HMS until 1946. He later entered private practice in Providence, and in 1963 became professor of medicine at Rhode Island Hospital and Brown University, retiring in 1966. Dr. Fulton gave this paper on May 11, 1977 at the Seventh Annual Meeting of the American Osler Society. He died suddenly five days later.

I arrived on this Oxford scene with a fair knowledge of Osler, thanks to having lived, while a student at Brown University, with my uncle, Dr. Frank T. Fulton, who had graduated in the third class to finish at Johns Hopkins Medical School in 1899. I had heard of Osler many, many times. To me, my uncle was a veritable James Bovell. So deep had my own interest become that when I was privileged to give an address at my Brown Commencement, I spoke on Sir William Osler. These facts gradually became known to Lady Osler after several delightful, albeit a trifle frightening, meetings at 13 Norham Gardens. And then one day, after I had asked her one or two apparently intelligent questions, she said in her characteristic, very direct way, "You seem to know quite a lot about us!" That afternoon I carried home, as a gift from her, paperback copies of both *A Way of Life* and *Science and Immortality* — trifling little volumes perhaps, but they meant a great deal to a hero-worshipping young medical student.

An even greater thrill came two months later when I found, on returning from a Christmas vacation, a sizable book, enclosed with a note:

Dear Mr. Fulton:

I should like you to become used to reading "Osler" while you are in Oxford – I send you the next Edition (English) so that it may become part of your life here and be associated with what I hope proves more interesting every term. A Happy New Year to you.

It was the *Principles and Practice of Medicine*. Here indeed was proof that the "way of life" of thoughtfulness and caring, and giving pleasure to others which had so dominated the day-to-day living of these two wonderful people still went on with Lady Osler. Membership in the Latchkeyer Club soon came about and without any fanfare. There were three or four of us at the time I was there. It meant a front door key with the unlimited privilege of coming whenever

The library of the Osler home

"Do you boys all know that you must *not try to live through an Oxford winter with American boxer shorts."*

one wished, to browse and study among the books, sit by an English hearthside, or play tennis on the garden lawn. Among the other latchkeyers was John Fulton — not a relative of mine, but a warm personal friend. It was really wonderful to watch the growth of bibliophilia, even approaching bibliomania, in this remarkably able and brilliant young man. In very short time, he was way ahead of all of us and Dr. Francis was putting him to work on esoteric problems, sleuthing among the books. Another was a delightful Britisher, Arnold Muirhead, who, though not a medic, was an avid bibliophile. After leaving Oxford, Arnold kept in close touch with all that went on at the Open Arms, and in 1931, several years after Lady Osler's death, he published a charming memoir of her which was privately printed at the Oxford Press. And Harvey Cushing was there, working on his biography of Osler.

Of course, the greatest privilege of all was the opportunity to come to know Lady Osler. The attribute that comes first to mind was her great concern for others. This encompassed every degree of a full circle — from the lonely undergraduate or beginning medical student, to the young wife about to have her first baby, to the elderly inmates at Ewelme — all of whom she knew by name and often visited — right on up to the thousands who, during the war, needed the supplies prepared by the Oxford Needlework Guild, which she ran with the help of some fifty to a hundred other volunteers. She cared deeply for all of her friends and their people. This concern was a natural expression of her unusual warmth of personality, for in addition to her graciousness, she had a sensitive and motherly touch. More than once, I heard her admonish American students on how best to get on with their confreres in England and then ask them, "Do you boys all know that you *must* not try to live through an Oxford winter with American boxer shorts. Go get yourselves some long johns, now, and don't try to be proud or arrogant."

During World War I, a number of professors from Louvain, Belgium, and their families took refuge in Oxford after the sack of their city. It was Lady Osler who found houses and clothing for many of them and who could write to her friends, "At present we have fifteen professors with their families — about eighty persons under our care." She summed up her efforts less seriously by telling her friends that whereas a few months previously, she scarcely realized that professors existed in Louvain, she now knew exactly what size in underwear each professor needed.

Her pithy letters were a particular delight, such as the one received from her while I was on a vacation in Jersey:

Dear Marshall:

You are lucky to have been away from here. I have never seen such dull and depressing weather. I was glad to have your letter and know you were fit and had been out so much – It is a wonderful island and I hope you have sun and warm weather before you leave. Do not come back until the last moment or give any time to dancing in London. We are very calm here and miss Archie very much. He is too busy to write more than cards but he will have plenty to tell on his return. I have done nothing but go to funerals and offer sympathy – which is not very enlivening. Much love – and enjoy yourself.

Lady Osler

Over and over one reads of the remarkable hospitality that characterized Number 13 Norham Gardens. Much of this, of course, related to Sir William's friendly generosity in asking people to lunch, tea or dinner. But who encouraged that? She did! It was Lady Osler who made it possible to call their home "The Open Arms." Sir William, himself, once wrote from Oxford to one of her nieces, "Aunt Grace is wasted here on this place; she ought to run a summer hotel." She loved being hospitable, and took pride in managing her household. She was unusually successful in keeping help, so that she could extend hospitality comfortably, in a dignified way

13 Norham Gardens

The Osler drawing room

Osler's grandniece, Marian Francis Kelen, M.D. — shown above as a child — was among the listeners to Dr. Fulton's talk, and she herself spoke about her father, W. W. Francis.

and with utter propriety, but without any show or ostentation. One never knew, even in my era, how many might come to tea — maybe two, maybe two dozen. This was no problem. Often with a smile or a chuckle, she would say, "I used to tell Sir William that it was all very well for him to preach, 'Have no thought for tomorrow' but if *I* did that, the refrigerator would be empty in no time."

She presided at the tea table, as Muirhead well puts it, "with all the air and manner of a duchess" — and sometimes appeared a little abrupt in manner. While this abruptness could all melt in an instant, it was but a part of another dominant trait in her makeup, her forthrightness. While gifted to an unusual degree with both tact and understanding, she could deliver a squelch at the appropriate moment that could really be devastating. Perhaps best known was her succinct message to Sir William, who while abroad in 1904 was indecisive about leaving Hopkins and accepting the Regius professorship at Oxford. Her short cable read: "Do not procrastinate. Accept at once."

On one occasion in Paris, she and her sister were being followed by an annoying admirer. When stops at windows, or even in stores, failed to shake him, Lady Osler, in mock exasperation, spun around on him, flashed open her umbrella nearly in his face, and said "Shoo!" The sad sack vanished.

Imagine an American housewife, newly arrived in England, picking out a bathtub for a remodeled bathroom. What better way to size it up than to get in it, which is exactly what she did, fully clothed, to the great consternation, as well as the amusement, of her British plumber. As Osler, himself, so aptly put it, "It's very hard to live up to these Boston women."

Any student of Osler is well aware of Lady Osler's great devotion to Sir William. Who possibly could have provided more completely the kind of home he wanted and loved? He, himself, acknowledged, "Of the greatest of all happiness, I cannot speak — of my home. Many of you know it, and that is enough."

In my brief era, Lady Osler was at her best during the quiet moments spent reminiscing about him. Her major concern was his books. Much as she dreaded the thought of the books leaving Norham Gardens, she knew how McGill would love to have them, and she pressed for the completion of the catalogue. This task, so carefully and skillfully handled by Dr. Francis, Archie Malloch and Reginald Hill, took seven years to finish. The first boxes for moving the books to Canada arrived the day before Lady Osler died in August, 1928.

Her obituary notice was written by Professor Arthur Thomson of Oxford, whose description read, in part: "Her dignified presence, her charm of address, her sincerity of purpose, coupled with a tenderness essentially feminine, has ensured . . . . a memory ever fresh and desirable."

Who's Who: *James Bovell,* as medical director of Trinity College School in Ontario, steered the young Osler toward medicine. *William W. Francis,* Osler's nephew, spent nine years preparing material for and overseeing publications of *Bibliotheca Osleriania,* the catalog of Osler's library. *John F. Fulton,* a Rhodes Scholar, became a distinguished neurophysiologist and historian of medicine. *Reginald Hill,* of the Bodleian Library, helped edit the Osler Catalogue and compiled the index for Harvey Cushing's biography of Osler. *Archibald Malloch* was librarian of the New York Academy of Medicine. *Arnold Muirhead,* a rare book dealer in St. Alban's, England, wrote Lady Osler's biography. *Sir William Osler,* a clinician of great stature, was the most influential medical educator of his day, and an early proponent of bedside teaching. *Wilder Penfield,* like Marshall Fulton, was a Rhodes Scholar, a graduate of Oxford and of Johns Hopkins Medical School, and house officer at the Peter Bent Brigham Hospital. He was a distinguished neurosurgeon and professor of neurology and neurosurgery at McGill University from 1933 to 1960. *Sir Charles S. Sherrington,* a British neurophysiologist and professor at Oxford, was noted for his analysis of the integrative action of the nervous system. In 1932 he received the Nobel Prize for his work on the function of the neuron.

— G. E. Gifford

One corner of Puerto Rico

by Yeou-Cheng Ma

I had the good fortune of working in the Health Center of Rincón, Puerto Rico during January and February of 1977, through an elective program sponsored by the nutrition department of the Harvard School of Public Health. The prospect of arriving alone in an unknown land, where I had neither friends nor relatives, where the language and culture were unfamiliar, was both awesome and exciting. I had hoped to acquire, in these two months, experience in the management of outpatient problems, fluency in Spanish and an understanding of a small segment of the Puerto Rican people.

Under the guidance of the doctors and with the support of the nursing staff, I gained confidence in my work as well as valuable insights into the needs of the people in response to a rapidly changing society. I saw common health problems in a different setting, and was stimulated to consider the vital questions of the social and cultural determinants of attitudes and behavior, the economic realities affecting nutrition and education, and the allocation of limited resources to benefit the most people.

Rincón (literally "corner") is a town on the northwest coast of Puerto Rico, about twenty-five miles away from Mayagüez, the nearest referral center. It consists of ten sparsely populated "barrios" (neighborhoods) including Puntas, famous for its surfing. Fifty to sixty per cent of its population of 10,000 is unemployed and subsisting on welfare; the rest works in fishing, farming, tending shops, harvesting sugar cane, and in nearby factories and businesses. Nothing detracted from the magnificent landscape, which I admired every morning while commuting from Mayagüez, where I stayed in a dormitory for nurses and medical students.

A typical day starts around 8:00 a.m., when the medical team checks on the handful of inpatients admitted during the night:

. . . A young child is kept for observation and rehydration for diarrhea and vomiting — these children so often cease having symptoms after absorbing some intravenous fluids that some mothers attribute magical properties to the *suelo* (serum) administered, and demand it when the child has a stomach ache, a cold, loss of appetite, or any other complaint.

. . . Another child has come in with refractile asthma, and a question of pneumonia by physical exam. The clinical diagnosis awaits confirmation by x-ray (although the health center recently acquired x-ray equipment, there is no technician at night or over the weekends). The films are read by the doctors, and a few are selected for the radiologist who reviews films once a week with us for an hour.

. . . A young woman with a history of recurrent urinary tract infection and stones, presenting with sudden flank pain and bloody urine, waits for this stone to pass.

Yeou-Cheng Ma graduated from HMS last June. She is currently an intern in pediatrics at New York University Medical Center.

There are also a couple of longer-term boarders.

. . . A ninety-five year old gentleman, who had increasing difficulty swallowing food for a few months, can now barely tolerate sips of water. The cancer at the base of his tongue has spread to such an extent that he is not considered a suitable candidate for surgery or radiation therapy. After every shift the nurses report to us their failure at feeding him; we can no longer find veins to give him intravenous fluids, and he has repeatedly torn out the nasogastric tube we attempted to use. He greets us with an angry roar, thrashes around in his restraints, and grabs an arm, reaching out for some understanding of his hunger, frustration and fear of impending death.

. . . A seventy-four year old woman with distal gangrene of three toes (due to arterial insufficiency), was admitted for treatment of congestive heart failure. She is being considered for arteriography, in search of a systemic disease (such as arteritis), because she has unresolving hepatomegaly, and ascites with decreasing edema. One of the doctors notes some petechiae on the soles of her feet. She exclaims indignantly, "I do *not* have petechiae, I have gangrene, but *no* petechiae!" This same woman was heard to remark to a nurse later in the day, "What these doctors don't seem to understand is that I have this fungus on the foot for which I have a balm at home that I should try."

The health center, a one-story building, is close to the center of town — a cluster of small shops, one bank, one post office, two bars, and four pharmacies. It consists of an emergency room, several doctors' offices, a labor and delivery room, and facilities to accommodate ten inpatients. In addition it has its own pharmacy, a laboratory for routine blood and urine analysis (not including electrolytes or bacteriology), and electrocardiograph and x-ray equipment. Staffing the center are four licensed, full-time doctors (one woman and three men, of whom one was trained as a surgeon, the others as internists) as well as several medical students and nurses. The quality of medical care offered is supervised by the chief of medicine at Mayagüez Medical Center, who visits at least once a month to audit records and consult on difficult cases.

At nine, the crowds begin to gather, waiting in line to be seen by the doctor in the triage area, to be sent to either the emergency room or the walk-in clinic. Meanwhile, other patients, with previously defined problems, are scheduled for the specialty clinics — pediatrics, diabetes, cardiology, minor surgery, medical comprehensive, family planning and dental. Patients needing consults to other specialties such as dermatology, obstetrics and gynecology, surgery, neurology, hematology or complex diagnostic procedures are referred to Mayagüez. Unfortunately, the average wait for an appointment at the referral center is at least three months — a tolerable interval for an audiology follow-up on a child with a ruptured ear drum, but an unbearably long time for a seventy-one year old woman with a third degree prolapse of the uterus, who lives alone and can hardly walk around from the discomfort of it.

Only about five to ten per cent need immediate care — during several days when workers were drilling through the walls, prior to installing air conditioning, only a small fraction of the usual fifty to two hundred patients appeared. On Sundays the health center is mobbed: many people drop by with their whole families after church, bringing their weekly bodily grievances as they clear their consciences at confession. Even members of the family who feel well are encouraged to recount their transient ills — "Didn't you say you had a headache yesterday after dinner? And what about the cramps in your legs this morning?"

Two emergency patients left an indelible impression on my mind. The first was a thin twenty-four year old woman who complained of back-splitting pain of sudden onset. She had some menstrual irregularities for two months and thought that she could be pregnant. An hour later, her blood pressure dropped from 110/70 to 80/50, with a weak, thready pulse. She was rushed to the Mayagüez Medical Center emergency room with an intravenous

line wide open to avoid impending shock (there is no blood bank at Rincón). After consulting two surgeons she was taken to the operating room, where she was found to have a ruptured ectopic pregnancy in the left Fallopian tube, with two liters of free blood in the abdomen. Three days later, she ambled through the outpatient clinic at Rincón, with her three young children, complaining that the doctors at Mayagüez did not treat the urinary tract infection they diagnosed. Never had I been happier to prescribe antibiotics for someone.

The other emergency case I will not soon forget was an eighteen month old boy who had fallen from a tree a week before, and was not seen by a doctor at the time. He was brought in with increasing irritability; fifteen minutes later he stopped breathing, turned blue, became cold and clammy. Efforts to resuscitate him on the ambulance to Mayaguez were of no avail, despite the care of the four accompanying doctors. A shocked silence settled over the whole staff of the health center. We were not surprised by the rash of young patients brought in during the next week, to be checked after alleged falls. But we were puzzled by the case of a six year old girl brought in to have her "swollen glands" checked; she was perfectly free of symptoms and of abnormal findings on the exam. Only when the nurses informed us that she lived on the same street as the boy who died did we understand her grandmother's need for reassurance.

There seemed to be a strong psychological component to the illnesses of most of the patients I saw — possibly due to the restrictive influence of the traditional Latin mores, which are often discordant with the rapidly changing times. Even in the dormitory at Mayagüez, men and women are on separate floors and can only visit on the ground floor, under the surveillance of the dorm "mother" and a guard. I have been told that this is a vast improvement over a few years ago, when parents would allow young men to visit their daughters only if the young people sat at opposite ends of the couch, and the parent in the middle! In Rincón, a much smaller town, mothers are shocked by questions about a possible pregnancy in their unmarried daughters (in the evaluation of abdominal pain), and a twenty-eight year old woman is not allowed to leave the house unchaperoned, even to buy groceries (this woman had the symptoms and was being worked up for thyrotoxicosis, but had perfectly normal values for thyroid hormones).

The people of Rincón gave me a special welcome, because most of them had never seen a Chinese person before. I was taken aback at my ability to stop traffic just by stepping into the street, and surprised to hear from the nurses that the school children who gathered at the health center during lunch hour came for no other reason than to look at the "Chinita" (little Chinese one). While in Puerto Rico, I enjoyed the hospitality of several families and the company of numerous colleagues. They shared their daily life with its joys and troubles, and went out of their way to show me around the island.

My relationship with the other medical students, doctors and fellow workers was characterized by mutual respect and affection. I especially admired the dedication and compassion of some of these young physicians, their detailed attention to the management of the total patient (given the often stringent limits of available resources), and the healthy balance they maintained between the intellectual satisfaction of confirming a clinical diagnosis by time-consuming and expensive tests, and the necessity of alleviating symptoms and suffering.

The delivery of health care in Rincón can be put into perspective by considering that as recently as two years ago, the health center, with no physicians, laboratory or x-ray facilities of its own, had to rely on the intermittent services of two general practitioners. The physical improvements and hiring of full-time physicians were made possible by a federal grant through the National Health Corps. The size of the patient population is increasing rapidly as they realize the excellent quality of free health care accessible to them through Medicare.

Patients come with varying levels of sophistication, their chief complaints ranging from self-diagnosed conditions, such as nervous condition, allergies, kidney pain, and lung pain, to alleged diagnoses of rheumatic fever, kidney infection, asthma. Some not only insist on

telling the doctor what they think is wrong with them, they even prescribe their own remedies. A reliance on pills and shots has been fostered by some of the doctors the patients have seen previously, or are currently seeing outside of the health center. There is at least one local general practitioner whose unconventional remedies (including repeated steroid injections for osteoarthritis, daily intramuscular shots of erythromycin and lincomycin for colds and for cellulitis) have brought consternation to the workers in the health center and sown confusion in the minds of the patients. The surprise and reluctance of many patients to be examined for their complaints before getting their pills or shots attest to the gradually shifting emphasis towards more precise etiological diagnosis before handing out symptomatic relief.

Many of the problems are beyond the direct jurisdiction of the practicing doctor. Although malnutrition is not as great a problem as in areas such as Apartadó, Columbia [*HMAB Nov./Dec. 1975*], where there is an absolute deficiency of protein and calories, there are selective deficiencies. Most of the children I saw were deficient in iron,

"On Sundays the health center is mobbed: people drop by with their whole families after church, bringing their weekly bodily grievances as they clear their consciences at confession."

partly because most families cannot afford to eat meat frequently, and children may not eat iron-rich substitutes out of fussiness. In the case of the elderly, there is a real need for home care and follow-up, such as provided by a social worker, public health or visiting nurse. This would save many a patient the daily trip to the health center for a vitamin B_{12} shot, insulin shot, or local wound care for chronic ulcers.

A promising way of dealing with some of these problems is through patient education, and allowing family members to play the roles of these missing health workers. There are several nascent efforts at the health center to provide public information on diet, health care and maintenance, dental hygiene, and family planning, through classes and posters. If these could be supplemented by classes about nutrition and health in schools, and adult community activities, it would be an efficient and inexpensive means of encouraging people to take responsibility for their own health.

Yet there is always the resistence of inertia. Within the health center itself, despite the plea of the medical director, the standard fare of rice and beans is fried in lard. The seventy-year old woman in charge of the kitchen, who has never been in school for a single day goes over the patients' diet cards daily with a staff member. A "low salt," "diabetic" diet is taken to mean no added salt or sugar, without regard for their presence in canned foods.

Compliance with instructions clearly varies greatly from patient to patient, and is also dependent on the issues at stake. It is relatively easy to talk a sixteen-year old adolescent out of a request for a "nerve pill" to calm the emotional storms of that age, by discussing viable outlets within a rather constricting social structure; or to persuade patients weighing two hundred to three hundred pounds that they may indeed lose up to twenty pounds in two weeks by taking diet pills, but that they may easily regain that weight, or more, within a month if they do not eat less or exercise more; similarly many patients can be persuaded to forego unnecessary shots and antibiotics. But there are more difficult cases: how to persuade a thirty-six year old diabetic to use insulin instead of oral hypoglycemics when neither the patient nor the family is willing to handle syringes and needles, and they live far from the nearest pharmacy; how to diagnose and treat a perennially angry sixty-five year old man with all the symptoms of benign prostatic hypertrophy who refuses to be examined, and insists on having an "x-ray of his prostate" taken; how to persuade a fifty-three year old woman dying of lung metastases from breast cancer that the oxygen therapy she demands and clings to as a last ray of hope is not sufficient cause to hospitalize her, although her family refuses to pay for the oxygen at home.

But communication goes two ways. Some patients surprise us with their view on the etiology and cure of disease. A sixty-eight year old man reports dysuria and rash worsening on exposure to sunlight (preliminary screening for porphyria is negative). On follow-up, he reports improvement of symptoms with pyridium, *guarapo* (herbal tea), but worsening with coffee. A seventy-five year old woman with congestive heart failure, chronic obstructive lung disease, adult onset diabetes mellitus resulting in a three-stage amputation of one leg, sighs as she patiently explains that her respiratory distress is caused by her diabetes. Her care-worn, deeply wrinkled face bespeaks a life of silent suffering, yet she insists on dressing herself, moving herself from bed to wheelchair, her frustration and anger at her weakness thinly masked by her courage.

During my stay in Rincón, many questions were raised; few were entirely answered. Yet the experience helped me focus on the importance of coordinating patient education with simultaneous environmental intervention in any program of preventive medicine. I saw the impact that a few energetic young doctors had in changing the quality of medical care delivered to the people of Rincón, and I hope that future medical students will share in the excitement of participating in this group effort to involve people to help themselves.

LOW COURSE ON THE TOTEM POLE ?

The Alumni Survey Committee was asked to study the Introduction to Clinical Medicine (ICM) because feedback, both from students and faculty, appeared to show not only that there was variability in the material taught, but also that students had an almost uniformly negative reaction to the course. Later in the core clinical clerkships, faculty complain that students are often poorly prepared. In preparation for this report we met with certain members of the curriculum committee, the board of advisors of medical students, the hospital coordinators of the ICM, and a group of students picked from the various hospitals where the ICM has been taught. Once again all of the doctors we spoke with seemed concerned, interested and dedicated to the cause of getting the students into the clinical phase of medical school in the quickest, most painless yet most instructive way. Tremendous effort and considerable time has been taken, particularly on the part of each hospital coordinator, in arranging the courses, lining up instructors, finding appropriate patients, and planning schedules. Once again, when we came to the end product — the student and what he or she had learned — there seemed to be obvious frustrations and deficiencies, sometimes of great magnitude. Particular problems seemed remediable, but not all.

Historically, starting in the 1950s this course consisted of two parts: sessions on physical diagnosis late in the second year, and in the third year "Introduction to the Clinics," structured as an outpatient experience at the hospital. Other clinical courses such as surgery, pediatrics, and ENT rounded out the third year. In the early 1960s, both Introduction to the Clinics and physical diagnosis were rather substantially redesigned every three to four years, since the students and often their instructors felt that the course was not relevant enough, was being given too late in their training, and was in competition with other courses. Even with experienced leadership each time from various professors, Oliver Cope and Alexander Leaf to name two, trouble of sorts persisted and change in some degree has occurred almost every year since that time.

By 1968 the course had evolved to the point where late in the second year the students were taking physical diagnosis and ITC twice a week, and block cell biology and pathophysiology courses the rest of the week. Again it was soon appreciated that these courses were in competition with each other. The next trial combined physical diagnosis and ITC exclusively all day, every day for eight weeks in February and March of the second year. Again the students complained of taking physical diagnosis in one hospital, and ITC in another; they professed dissatisfaction and confusion over this kind of fragmented learning experience. A major change was clearly needed. In 1972 and 1973 isolated hospitals experimented with offering both physical diagnosis and the ITC in the same hospital, hoping this might prove more satisfactory.

From all this turmoil the present course, now known as the Introduction to Clinical Medicine, evolved. Given in the spring term Mondays, Wednesdays and Fridays from 8:30 a.m. to 4:30 p.m. with only one prerequisite — pathophysiology — ICM is again combined Tuesdays and Thursdays with another "700" (longitudinal) course. The same problem of competition is back and, depending on the other studies and inclinations of the student, one of the two courses may be neglected. The present ICM course description in the *Schedule for Courses* reads: "to provide instruction in the basic techniques of interviewing and examining patients and the methods of clinical problem solving." It is taught at the MGH in the first semester and at the Beth Israel, Mt. Auburn, Cambridge, the Peter Bent Brigham and West Roxbury VA, the New England Deaconess and the MGH in the second. The first twenty sessions are intended for teaching physical diagnosis and history taking, and the remainder, differential diagnosis and problem solving. Thus it incorporates the old physical diagnosis course.

Like its predecessors, the current ICM uses the small group method. A handout written by each hospital course coordinator is usually, but not always, given to the students at the

(continued on page 36)

The Alumni Survey Committee, under the chairmanship of William D. Cochran '52, studied the status of the Introduction to Clinical Medicine in the spring of 1976. The members at that time included Joseph W. Burnett '58, Granville C Coggs '53, Ruth C. Haynes '52, James R. McArthur '56, Donald McLean '43A, Scott Nelson '66, Philip Partington '35, and Marshall deG Ruffin '36 The report was discussed at the May 1977 meeting of the Council, with four of the ICM coordinators in attendance: John A. Mills '66 of the MGH, W. Hallowell Churchill, M.D. of the Peter Bent Brigham, William P. Beetham, Jr., M.D. of the New England Deaconess, and Charles Hatem '66 of the Mt. Auburn. The discussion, which touched on many points, is paraphrased in the coordinators' response (below) authored by Dr. Mills.

The strength of the Introduction to Clinical Medicine at HMS results from several factors which are not to be found at many other medical schools — the participation of a large number of practicing physicians, the involvement of some six hospitals each with its own strengths and its own orientation to the problems of providing medical care, and a devoted group of coordinators who are trying to the best of their abilities to make this an outstanding course.

The Alumni Survey report pointed out that the objectives of the course were poorly defined. In a sense this is a very open-ended course because a physician never completes being trained in history taking, physical examination, and the various ways of relating to different patient personalities. It is possible to identify certain fairly obvious goals, which are outlined in the course syllabus. At the completion of the ICM, students who will be starting their clerkships should be able to establish a mutually satisfactory relationship with a patient, obtain the information required for a competent diagnostic evaluation and be able to present that information verbally and in writing so that it makes sense to a group of colleagues. It is not difficult to draw up a list of specific objectives and to assign them priorities. However, no two students will come away with exactly duplicate experiences given the limited time available. The emphasis is on teaching a clinical method, not on specific experiences.

A related concern identified in the report was the lack of uniformity in programs at different hospitals. As coordinators we regard this in a positive sense. The fundamentals of the programs are not greatly different. Such variation as there is represents either an attempt at something new in a given year or an accommodation to some specific logistical problem at that institution. Each year the coordinators have devoted at least one of their meetings to discussing the previous year's experiences, their successes as well as their failures. The course probably would not be improved simply by insisting that it be taught the same way at each hospital.

It was noted in the Survey report that the quality of teaching appeared to be uneven. Having chosen to make the ICM an individual preceptorship for the students, we rely heavily on the teaching abilities of individual physicians. It is at best difficult to recruit the large number of instructors required, whatever their abilities as teachers. All of the clinicians on the faculty are busy and increasing demands on their time are being made each year. They all do a great deal of teaching not only for medical students but for residents, trainees in fellowships, and in an ever growing number of postgraduate courses. Because individual instructors have different backgrounds, interests, demands on their time, and ideas about what should be taught there is bound to be variability among student experiences. There is no question that students' satisfaction depends mostly on the ability and personality of their instructors, how much time they spend with the students, how sensitive they are to individual student needs or problems and how well organized in their teaching.

Our ability as coordinators to recruit instructors at each of the hospitals is closely related to another problem identified by the Survey report — namely the lack of priority given to the course in the hierarchy of teaching activities and the lack of recognition given to those who teach it. Many if not most of the teachers are junior faculty who find themselves confronted by many obligations. Other than the grateful response of the student there is not much tangible reward for teaching the course. The clinical instructors need guidance and encouragement from their chiefs. It must be made clear that this is an important course and that the instructors will be recognized for teaching it. Its importance must be made clear in comparison to other activities, such as writing a paper, being a ward visit, or participating in a postgraduate course.

The Survey report pointed to the lack of audiovisual aids in the ICM course and it is true that for the class as a whole the matter has been approached haphazardly. Many of the coordinators use such teaching aids to some extent and most

(continued on page 38)

beginning of the course. Each handout and presentation naturally differs from the others. If available these handouts usually state that the course will be broken up into two parts, the first being the mechanics of the examination and the interview and the second being devoted to the methodology of problem solving. In greater or lesser detail they define the goals of the Introduction to Clinical Medicine at that hospital, the patient interview, the physical examination, the writing of medical records, and the method of oral presentation. None seem to delve much, if any, into the details of how to introduce oneself to a patient for the first time as a doctor (or student), nor do they explain to the instructors the need to address this sensitive subject. Furthermore, at most of the hospitals there is no mention of any teaching aids, films of doctor-patient interviews or examinations, and the like. There were no recommendations to the preceptors about demonstrations on or examinations by themselves — apparently leaving these options to the various courses' main coordinators.

It bears reemphasis that there is great enthusiasm and dedication, especially on the part of the hospital coordinators and of the main coordinator, John Mills of the MGH, to develop and implement a successful ICM. The constant modification of the course has led to certain imbalances, since the hospital coordinators have designed their own courses within broad guidelines that allow great latitude for variation.

Course Standardization

- The ICM is not carefully standardized and has no clearly stated educational objectives. Though the course was outlined for the students in a manual, "Clinical Diagnosis (an Introduction to Clinical Medicine) October 1975," each instructor and preceptor obviously is not so sure where he or she fits into this complex and changing educational labyrinth. No syllabus is available for the teaching faculty. For the year 1976-77 even the student syllabus was not handed out to all the students, as there was not enough common agreement about what should be in it. Each hospital had the option of writing and providing its own.
- In several hospitals there was often no long-term relationship between clinician and student. When this kind of association did occur it was always highly appreciated by both parties. Since students in certain hospitals changed their preceptor every three sessions, no mutual concern or benefit could be established. Students felt inhibited about asking more personal questions and expressing their anxieties to someone who barely knew their names. (It is important to note that previously one of the problems with the intensive block course, where instructors were involved five days a week, was that few were at all happy to give up that much time. However, they did get to know their students well. The present division of students among several instructors should enable them, with some reduction in their patient schedule, to maintain their practices as well as teach the students.)
- There was no standardized input from other specialities, besides medicine and surgery. As a result, some students were taught little or no ophthalmology, for instance. Each hospital should capitalize on its particular subspecialties, but as some have no appropriate ones, this might create problems.
- No general instructional films of a physical examination or a patient inverview were presented to the whole class. Usually an unstandardized didactic session at the individual hospitals began the course. All the coordinators had to do their own thing, and while that breeds individuality and freedom it certainly does make for more work and uneven levels of learning.
- There probably was too much of "this is the way we do it here" with little evidence of cross-pollination as to how a problem might be dealt with in the other hospitals. Dr. Mills did meet with all the hospital coordinators, some four times a year, yet they were unable to agree on a common body of teaching.

Recommendations

Standardization of Introduction

1. After a possible review of the different methods of teaching as well as the experiences of other medical schools, a standardized introduction of a day or two should be attended by everyone. Films and other visual aids, and physical examinations done by the students on each other and on their preceptors, should be mandatory. A sensitive discussion of the first confrontation between patient and student should take place — and a filmed example would surely be helpful. Occasionally, some of the students will have had a course on history taking; these students therefore could eliminate parts of the introductory session.

Standardization of Course

1. Attempts should always be made to utilize the same faculty member per student group for as much of the course as possible.
2. A general meeting of *all* faculty from *all* involved hospitals should take place at least once a year.
3. All faculty should be made aware of what it is they are expected to teach and what the students have been taught already. All students should be evaluated using a standard format.
4. The use of audiovisual aids should be encouraged, and all the coordinators informed of their availability.

Faculty and Priority

- Often inconvenienced in time and effort in working with the ICM, the instructors understandably approached their duties with mixed emotions on occasion. The course coordinators put in even more time than the average instructor — for they both organize and teach. (It is indeed a sad commentary for them that after all this effort they continue to hear that the course is not as successful as it might be.) In some of the hospitals the instructor does not even know the patient to whom he or she and the student have been assigned, and too frequently the instructors do not have enough time to teach. Though unbelievable amounts of time are taken in organizing faculty for preceptorships and arranging faculty teaching around their own research and patient care needs, we still heard that there was not enough time to plan relatively standardized coordinated courses. There seemed to be negligible support from those in higher authority (professors of medicine or surgery). Instead the ICM appeared to be the least important of the clinical courses, in lower esteem than even the core clinical clerkships we reported on earlier.

"There was probably too much of 'this is the way we do it here' with little evidence of cross-pollination as to how a problem might be dealt with in the other hospitals."

Recommendations

Increase the priority for the ICM

1. The department heads, senior faculty, and the dean must lend greater support.
2. Doctors must educate patients that these young students are in need of instruction, and that they can help. Physicians have to urge their private patients to become involved in the teaching effort whenever possible, thus increasing the pool of inpatients for the course.
3. Senior and emeritus/a faculty should teach, too, thus lending distinction and experience to participating in the ICM. Emeritus/a faculty, with fewer demands on their time, could provide more continuity in teaching and advising students.
4. The hospital course coordinators must be given more support and more time to plan a core introduction as well as a standardized course. There is a particular need for carefully instructing the preceptors themselves as to where they fit into the ICM as a whole.
5. *Teaching should certainly be considered worth at least some credit for promotion and/or tenure.*

Students — Stress, Anxiety and Unhappiness

• There is much stress, tension, anxiety, fatigue and inconvenience — even a crisis on occasion — for the majority of the students at some time during this course. The students all admitted to moderate to great personal anxiety about their first encounter with a patient, and most felt extremely ill at ease on at least one occasion. Often they were introduced as "doctors" and disliked this subterfuge. The students recognized time and again that the patients had been overused and overexamined, and since they as students felt they had so little to offer the patients, they were embarrassed to impose further upon them. No matter how steeled a student might be, it was devastating to approach a patient only to be reproached, "I've already told this story five times before!" The students' lack of knowledge also caused extreme distress. In the classroom, one has the option of not speaking up; in interviewing and examing patients, students find themselves publicly "on the spot" for the first time. The lack of a standard or model as to what to do, and the expectations of the initial encounter with the patient exacerbated the uneasiness of the student.

Recommendations

1. Use of a standardized one to two day introduction should be instituted to help alleviate much of the apprehension.
2. Avoid insensitive use of patients. Certain possibly hypersensitive students felt that patients they examined or interviewed should as much as possible be informed that these were students (not doctors) examining them. If they responded at all negatively, then more compatible patients should be located. Patients should be spoken of as Ms., Mrs., Mr., and not by their first names, and certainly should not be referred to as "an interesting liver, gall bladder, or heart."
3. Students wanted an evaluation of their progress, or lack of same. Some of them expressed qualms about not measuring up in their first patient contact situation.
4. Recognize the special problems of the minority students. Though often denied by certain faculty, it was apparent that some minority students felt especially ill at ease when examining or even interviewing patients of another race. (Similar anxiety occasionally was voiced when opposite sex situations arose with common racial background.) Recognition and extra help should be offered to mitigate such situations.

Patient Stress

• Most patients are inpatients. Because there are some 160 students needing instruction, appropriate inpatients are hard to come by. Repeated examinations and interviews caused unhappiness and ennui on the part of the patient and led to even further student anxiety.

• Those few hospitals that utilized outpatients had more appeal to the students for two reasons: the patients were "fresh off the street" and had not been overly questioned by other residents and students, and the patients were not so sick, making the student feel more competent to the situation.

Recommendations

1. More use of ambulatory patients. They would appear to be more obliging, from the student's point of view, although their presence on successive days would be unlikely.
2. Patients should be told what is going to happen to them and, if appropriate, who the students are. They should be given the option of saying "No!"

(continued from page 35)

have reviewed an array of audiovisual materials ranging from terrible to superb: the better ones usually being very expensive — especially when they must be provided in six locations. If time were available we should develop our own, but to do so requires an expertise beyond what we possess in most cases.

Audiovisual aids are no substitute for bedside practice under an experienced and interested tutor. The ICM is a turning point of a sort in a medical student's life. After years of academic preparation, students come to the hospital apprehensive about whether they have chosen the right profession, and concerned about their reaction to being alone with a patient. After the first day or two a few fear that they are not cut out to be doctors. Nothing but a concerned instructor can help a student through this experience. Unfortunately, few if any instructors can free up the time to guide a group of students through the full fifteen weeks of the course. Most students have several instructors each of whom takes a small group through a particular phase of the course. This is unfortunate in terms of continuity of teaching, but it is an almost insurmountable logistical problem.

Finally, there were several references in the Survey report to the use, or overuse, of inpatients for teaching, rather than outpatients. Most of the participating hospitals now use both. The use of outpatients has some strong attractions. They are usually fresh in the sense that they have not already been interviewed by several residents as well as students. They often present with much more down-to-earth clinical problems and they look upon even the student as a provider of care — an exhilarating and challenging experience for the budding clinician. But there are also serious drawbacks. The clinic is a busy place and the patients are often busy people. Neither the time nor space is available for the long and arduous student workups. When every minute of clinic time is being cost accounted, it is relatively inefficient to use the "front line" for introductory teaching. Furthermore the nature of the patient's illness may not be known, there may be few physical findings, or the history may not provide a very valuable object lesson for the student.

Hospitalized patients, on the other hand, can be selected to provide whatever experience a student needs at a given point in his or her training. For the most part inpatients have more free time and enjoy the company of an interested and sympathetic student. The student does not feel under the gun since others have ultimate responsibility for the patient's care and he or she can learn by observing how specific clinical problems are handled.

We should not allow the course to become any more diffuse than it already is; what works well at one hospital should be implemented at the others. Students enjoy the opportunity to observe their instructor doing a complete history and physical. Conversely, it should be required, before the end of the course, that the instructor evaluate each student doing a complete history and physical. At the Beth Israel last year a cooperative effort with the Massachusetts College of Art worked out extremely well. Students there were examined by ICM students and their instructors, who both took a history and did a physical.

The exciting aspect of this course is that it can be set up much like a seminar. When one instructor stays with a small group of students throughout, he or she can have a tremendous impact on their direction. All of the coordinators are attempting to work out ways in which a longitudinal relationship can exist between instructors and students. Students fully enjoy the commitment of the Instructor to being with them a certain number of hours every week. Even though this can take its toll on instructors both financially and timewise, it can be one of the most constructive educational experiences at the Medical School, as long as it is supported as a worthwhile endeavor from the head of the department on down.

Letters

An irresistible trend

Since Dr. Curtis Prout's comments about the quality of family practice residencies [*HMAB, May/June 1977*] are at some odds with my own perceptions, I have undertaken to secure objective data concerning the satisfaction of Harvard Medical students with their family practice residencies. Questionnaires were mailed to forty-four family practice students (twenty-seven replies were received). A similar cohort of peers (fifteen replies were received) engaged in other residencies was questioned as to the satisfaction with their training programs. The results are tabulated below:

1. I rate my overall educational experience in my residency as:

	FP	Other
excellent	12	9
good	13	6
fair	1	
poor	1	

2. Educational experience in the model family practice unit/outpatient clinic has generally been:

	FP	Other
excellent	8	6
good	11	1
fair	5	6
poor	1	2

3. In-hospital rotations on specialty services have (26) have not (1) tended to provide supportive experience for family practice residents.

Simply put, Harvard students engaged in family practice residencies seem well satisfied with their experience and reflect no significant difference in this regard from their peers in other fields. My own interpretation of Dr. Prout's anecdotal comments in the *Bulletin* is that they reflect some institutional confusion as to the validity of the specialty of family practice.

NIRMP data list family practice as the second most common career choice of current medical graduates. A study of McGrath and Zimet presented at an

AAMC Conference on Research in Medical Education in November 1976 indicates that women students at the University of Colorado and California-San Diego have made this field their number one preference (44%). This sort of data seems slow to reach time-encrusted Harvard. Indeed when last year's student residency selections were announced in the Medical Area News Bulletin, *Focus,* those Harvard students selecting family practice as their career choice were subjected to the indignity of being lumped together with those selecting medicine. Such provincialism has never been one of Harvard's strengths.

The concept of a practice-focused education that trains young people to view patients in the context of their family, culture and environment will prevail. Harvard remains indifferent at its own peril.

Anthony D. Bower, M.D.
Instructor, Department of
Preventive and Social Medicine